

103
THE EMPLOYER MANDATE AND RELATED
PROVISIONS IN THE ADMINISTRATION'S
HEALTH SECURITY ACT

Y 4. W 36: 103-62

The Employer Mandate and Related Provisions in the Administration's Health Security Act
HEARING
BEFORE THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

FEBRUARY 3, 1994

Serial 103-62

Printed for the use of the Committee on Ways and Means



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THE EMPLOYER MANDATE AND RELATED PROVISIONS IN THE ADMINISTRATION'S HEALTH SECURITY ACT

THURSDAY, FEBRUARY 3, 1994

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The committee met, pursuant to call, at 10:45 a.m., in room 1100, Longworth House Office Building, Hon. Dan Rostenkowski (chairman of the committee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
TUESDAY, DECEMBER 21, 1993

PRESS RELEASE #18
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-1721

**THE HONORABLE DAN ROSTENKOWSKI (D., ILL.), CHAIRMAN,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A PUBLIC HEARING ON THE EMPLOYER MANDATE
AND RELATED PROVISIONS IN THE ADMINISTRATION'S
HEALTH SECURITY ACT**

The Honorable Dan Rostenkowski (D., Ill.), Chairman, Committee on Ways and Means, U.S. House of Representatives, today announced a public hearing on the employer mandate and related provisions in H.R. 3600, the Administration's Health Security Act (the Act). The hearing will be held on Thursday, February 3, 1994, beginning at 10:00 a.m. in the Committee's main hearing room, 1100 Longworth House Office Building.

In announcing this hearing, Chairman Rostenkowski stated: "The financing of the Administration's health reform proposal depends largely on the requirement that employers and individuals pay Federally mandated premiums for a guaranteed package of benefits. Because of the importance of these provisions, it is appropriate for the Committee to devote another day of hearings to the premium mandate in an effort to explore fully its implications for businesses and the workers they employ."

The Committee will take testimony from invited and public witnesses.

BACKGROUND

A. IN GENERAL

The Committee on Ways and Means has held a number of hearings on the Administration's Health Security Act and other health reform proposals. In its November hearings on the financing provisions of the Act and other health reform proposals (see press release #14), the Committee began its consideration of the employer and individual premium mandate provisions in the Act, along with the Act's other financing provisions. These hearings were held, however, prior to the formal introduction of the Act as H.R. 3600 on November 20, 1993.

B. EMPLOYER/INDIVIDUAL MANDATE IN H.R. 3600

H.R. 3600 would require all eligible individuals to enroll in an applicable health plan and pay their share of the required premiums (sections 1002 and 6101 of the Act). An individual's share of the premium payment generally would be 20 percent of the premium for the applicable class of enrollment for the health plan in which the individual is enrolled. Low-income individuals would be eligible for premium discounts (section 6104 of the Act).

The Act would require employers (including self-employed individuals) to make premium payments for qualifying employees either to the regional alliance or, if applicable, a corporate alliance health plan (sections 1601, 6121, 6126 and 6131 of the Act). The amount of the employer premium payment for each qualifying employee generally would be 80 percent of the weighted average premium for the individual class of enrollment in the regional alliance or corporate alliance health plan (sections 6121 and 6131 of the Act).

(MORE)

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A regional alliance employer's liability for premium payments generally would be capped at 7.9 percent of payroll (section 6123 of the Act). The cap would not apply to corporate alliance employers. Certain small business employers would be eligible for additional premium discounts equal to the amount by which their otherwise required premium payment exceeds the limiting percentage of payroll applicable to them. For employers with fewer than 75 full-time-equivalent employees and average wages of less than \$24,000, the limiting percentage would range from 3.5 to 7.9, depending on the amount of average wages and the number of employees.

The premiums paid by employers and individuals would include additional assessments to cover the costs of certain Federally financed programs, such as academic health centers and graduate medical education, alliance administrative costs, and collection shortfalls (sections 6101, 6107, 6125, 1352, and 1353 of the Act).

C. ISSUES TO BE ADDRESSED

The Committee asks witnesses who wish to testify at this hearing to address the following issues related to the employer mandate: (1) the appropriateness and effectiveness of using an employer/individual mandate as compared to other proposals to attain universal coverage; (2) the appropriateness and effectiveness of structuring subsidies for low-wage workers as premium discounts to certain types of employers based on firm-wide averages; (3) the impact of the employer mandate on the job market in the short and long term; (4) the effect of the employer mandate on employer-employee wage and benefit negotiations and on wages and benefits in the short and long term; (5) how the percentage-of-payroll cap and small business discounts might influence the way businesses structure their operations and the composition of their workforce; (6) the administrative, collection, and compliance issues arising in the way the Administration proposes to implement the employer/individual mandate; (7) whether the employer mandate will have different effects on employers electing to establish corporate alliances than on regional alliance employers and the extent to which employers are likely to choose to establish corporate alliances; and (8) the interaction of the employer mandate with the proposed limitation on the employee's income and employment tax exclusion (the "tax cap").

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD:

Individuals and organizations interested in presenting oral testimony before the Committee on any of the proposals specifically described herein must submit their requests to be heard by telephone to Harriett Lawler, Diane Kirkland, or Karen Ponzurick [(202) 225-1721] no later than close of business Thursday, January 20, 1994, to be followed by a formal written request to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. The Committee staff will notify by telephone those scheduled to appear as soon as possible after the filing deadline. Any questions concerning a scheduled appearance should be directed to the Committee [(202) 225-1721]. Please note that requests to testify must be made specifically for this hearing. Requests made to testify at the health reform hearings conducted by the Subcommittee on Health do not constitute requests made to testify at this hearing.

Persons and organizations having a common position are urged to make every effort to designate one spokesperson to represent them in order for the Committee to hear as many points of view as

(MORE)

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possible. Time for oral presentations will be strictly limited with the understanding that a more detailed statement may be included in the printed record of the hearing (see formatting requirements below). This process will afford more time for Members to question witnesses. In addition, witnesses may be grouped as panelists with strict time limitations for each panelist.

In order to assure the most productive use of the limited amount of time available to question hearing witnesses, all witnesses scheduled to appear before the Committee are required to submit 300 copies of their prepared statements to the Committee office, room 1102 Longworth House Office Building, at least 24 hours in advance of their scheduled appearance. Failure to comply with this requirement may result in the witness being denied the opportunity to testify in person.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:

Persons submitting written statements for the printed record of the hearing should submit at least six (6) copies by the close of business on Thursday, February 17, 1994, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements for the record of the printed hearing wish to have their statements distributed to the press and the interested public, they may provide 100 additional copies for this purpose to the Committee office, room 1102 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee:

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

*** NOTICE--CHANGE IN TIME ***

FOR IMMEDIATE RELEASE
WEDNESDAY, JANUARY 26, 1994

PRESS RELEASE #18-REVISED
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-1721

THE HONORABLE DAN ROSTENKOWSKI (D., ILL.), CHAIRMAN,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A CHANGE IN TIME FOR THE HEARING ON
EMPLOYER MANDATE AND RELATED PROVISIONS
IN THE ADMINISTRATION'S HEALTH SECURITY ACT

The Honorable Dan Rostenkowski (D., Ill.), Chairman, Committee on Ways and Means, U.S. House of Representatives, announced today that the hearing on the employer mandate and related provisions in H.R. 3600, the Administration's Health Security Act, scheduled for Thursday, February 3, 1994, beginning at 10:00 a.m. in the main Committee hearing room, 1100 Longworth House Office Building, will begin instead at 10:30 a.m.

All other details for the hearing remain the same. (See press release #18, dated December 21, 1993.)

Chairman ROSTENKOWSKI. I would like our guests to find seats if they are available.

Today, the Committee on Ways and Means resumes its series of hearings on the President's Health Security Act. In his State of the Union message last week, the President made clear that he would not sign a health reform bill which fails to ensure universal coverage for Americans.

To accomplish universal coverage, the Health Security Act requires a significant employer contribution to the costs of private health insurance coverage. This requirement known as an "employer mandate" is a fundamental feature of the President's plan. I expect our witnesses today to tell us about their concerns with this requirement and the potential consequences of its enactment.

Finally, we have a long day ahead of us, so I will ask our witnesses to limit their testimony to 3 minutes, if that is at all possible. The full text of each of your statements will be entered into the record, so that your entire statement will be included in the record.

When Mr. Archer joins us, I will ask our witness to yield and allow Mr. Archer, if he wishes, to make a statement.

Our first witness this morning is Bernard Brennan, representing the National Retail Federation.

Ladies and gentlemen, welcome to the committee.

Mr. Brennan, we welcome you, and if you would, for the record, all of you, as you testify, identify yourself for the record and then proceed into your testimony.

Mr. Brennan.

STATEMENT OF BERNARD F. BRENNAN, CHAIRMAN, NATIONAL RETAIL FEDERATION, AND CHAIRMAN OF THE BOARD AND CHIEF EXECUTIVE OFFICER, MONTGOMERY WARD AND CO.

Mr. BRENNAN. Thank you, Mr. Chairman.

My name is Bernard F. Brennan, chairman of the National Retail Federation and chairman and CEO of Montgomery Ward. I thank you for the opportunity today to testify on behalf of the National Retail Federation concerning the impact of the administration's proposed employer mandate on the economy and jobs.

Montgomery Ward is a Chicago-based company. We have 60,000 employees. We offer comprehensive health care to full-time employees and part-time employees working over 30 hours per week. Our company has a history of support for health care dating back to 1912, when we were the first company in America to offer such a plan.

We support the goal of affordable health care for all Americans. Specifically, we support the following important reform measures: Control of health care costs; voluntary health care purchasing groups; managed care and utilization review; elimination of pre-existing conditions to acquire coverage; guaranteed renewal and portability of coverage.

The retail industry employs 20 million people, 1 in 5 U.S. workers. Of the recent unemployed, 25 percent obtain new jobs in retailing. The retail industry has created 3.4 million jobs since 1979. Productivity data underscore the potential impact that the admin-

istration's plan would have on retailing. Each full-time retail employee produces \$1,740 in corporate earnings, compared to \$6,500 for a full-time employee in manufacturing. So it takes 3.7 more employees to produce the same earnings in retailing as in manufacturing.

The cost of the administration's new plan, \$1,440 for single coverage, would represent 83 percent of each employee's annual contribution to retail earnings. For family coverage, the cost would range from 129 to 193 percent of annual retail earnings per employee. We simply cannot afford the additional cost.

The administration plan would impose a \$17 billion cost increase on the retail industry, 59 percent of the total cost to all businesses of \$29 billion. It would greatly increase labor costs in retailing and other labor-intensive industries. A survey of 10 retailers employing 1.3 million employees shows that we would experience an 89 percent increase in health care costs until the 7.9 percent cap is phased in after 8 years.

The retail industry plans to continue to increase employment, but these massive cost increases would make that impossible. The preliminary estimate is that retailing would lose 500,000 jobs as a result of the administration's plan. There are 20 million employees in retailing. A modest 5 percent reduction alone would equal 1 million jobs.

To summarize the concerns of the retail industry, we believe that health care reform is essential, but reform must focus on covering Americans without health care, controlling costs, and reducing bureaucracy. Labor-intensive, low-margin industries cannot absorb the massive cost increases the employer mandate would require. As a result, the administration's plan would provide health care coverage for workers but at the cost of their jobs.

The retail industry wants to continue to serve our customers' needs while growing jobs for millions of Americans. We are ready to work with Congress to achieve health care reform that will provide access for all Americans and address the critical issues raised to date without jeopardizing our economy. Thank you.

[The prepared statement follows:]

**STATEMENT OF BERNARD F. BRENNAN
ON BEHALF OF THE
NATIONAL RETAIL FEDERATION**

**CHAIRMAN OF THE BOARD AND CEO,
MONTGOMERY WARD AND CO.**

BEFORE THE COMMITTEE ON WAYS AND MEANS

FEBRUARY 3, 1994

Chairman Rostenkowski, Mr. Archer, and distinguished Members of this Committee, my name is Bernard F. Brennan. I am Chairman of the National Retail Federation (NRF) and Chairman of the Board and CEO of Montgomery Ward and Co. I appreciate the opportunity to testify today on behalf of the NRF and to present the views of the retail industry and Montgomery Ward on the impact of the Administration's proposed employer mandate on the economy and jobs.

As a company with 60,000 employees, Montgomery Ward today offers a comprehensive plan to all full-time employees and part-time employees working over 30 hours a week. Montgomery Ward established a milestone in 1912 when it became the first American company to offer health care coverage to its employees.

Montgomery Ward and the retailing industry share the President's vision of quality, affordable health care for all Americans. Retailers need and want health care reform. Specifically, we support the following reform measures:

- **effective methods to control health care costs;**
- **efforts to encourage the formation of voluntary health insurance purchasing groups to make health insurance more affordable for individuals and small business;**
- **promotion of managed care and utilization review to control health care costs;**
- **insurance reforms which would eliminate the preexisting condition exclusion and guarantee availability, renewal, and portability of coverage;**
- **medical malpractice reforms which reduce defensive medicine practices and emphasize alternative dispute resolution; and**
- **administrative and paperwork reforms to simplify insurance claims processing.**

However, we want to stress that health care reform must not be achieved at the cost of our nation's economic health. Implementation of the Administration's proposed employer mandate would result in massive disruption to labor-intensive, low-margin industries such as retailing. We want to work with Congress and the Administration to ensure that the cure is no worse than the disease.

Why the Retail Industry is Uniquely Situated in the Debate on Health Care Reform

We believe that a successful health care reform plan must take into account the unique size, function and economics of retailing. Retailers employ 20 million people—one in five U.S. workers. Fully 25 percent of the recently unemployed obtain new jobs in retailing. Retailing contributes greatly to our nation's economic vitality. Between 1979 and 1992, the retail industry has created 3.4 million jobs,¹ while some other sectors of the economy have actually lost jobs. In addition, retail job creation causes an economic ripple effect through other industries. Every 10 retail jobs create 4.8 jobs outside of retailing – in

¹ Source: Bur. of Economic Analysis, U.S. Dept. of Commerce.

manufacturing, transportation, and other sectors.²

The job of retailing is to serve its customers. Many retailers -- like my company -- are open seven days a week, 11 to 12 hours a day (some even 24 hours a day) to accommodate the needs of today's customers. In addition, peak buying periods define much of the business. For example, a recent Arthur Andersen study shows that hourly sales velocity and customer traffic volume can vary by a multiple of thirty-five during different one-hour periods. In contrast to continuous production processes which require stable work schedules and accommodate full-time work shifts, these unique retailing factors make it necessary for us to maintain a very flexible workforce which includes large numbers of part-time and seasonal workers.

A recent study by an independent economic consulting firm³ confirmed that 73 percent of part-time employees choose to work part-time -- to supplement family income. Companies like Montgomery Ward and other large and small retailers provide the jobs which make ends meet for :

- millions of part-timers who are working mothers and single parents who need flexible schedules;
- older workers who want to keep active;
- teenagers getting a first taste of the working world with an after-school job; and
- college students working to contribute toward their educational expenses.

In addition to being highly labor-intensive and competitive, retailing profit margins are very narrow. Since 1990, more than 50,000 retailers have filed for bankruptcy. Forty-three of the top 100 department stores operating in 1980 are no longer in business.

The Administration's Proposed Employer Mandate Disproportionately Impacts the Retail Industry

Because a mandate would require employers to pay their employees' health insurance premiums and translates directly into increased labor costs, its impact will be felt most strongly in labor-intensive industries with high concentrations of lower-wage workers, such as the retail industry. The continued ability of Montgomery Ward and other U.S. retailers to create jobs and to contribute to national economic prosperity would be threatened by the massive new costs that the Health Security Act promises to impose on employers.

The Administration states that employer partnerships in the management, cost containment, and quality of health care are an important part of their plan for reform. However, as proposed, the Health Security Act discourages such partnerships by placing many disincentives on Corporate Alliances. These disincentives include:

- Ineligibility for the 7.9 % payroll cap;
- A 1% payroll tax would apply to all Corporate Alliances including the payroll of part-time employees required to join the Regional Alliance;
- All part-time employees would be required to leave their company plan and join a government run Regional Alliance or state-run single-payer plan;

² Source: Bur. of Economic Analysis, U.S. Dept. of Commerce; Dept. of Economics, University of Illinois at Chicago.

³ Source: The Trade Partnership, Washington DC.

- Low-wage income subsidies do not apply to Corporate Alliances, although they do to Regional Alliances. The result is that Corporate Alliance employers in low-wage industries may be required to pay up to 95% of their premium cost. This cost could be significantly higher than the 80% of the premium or 7.9% of payroll cap afforded to employees in Regional Alliances;
- Corporate Alliances would be forced to dissolve and join Regional Alliances if their costs run higher than the Regional Alliance;
- States could require a state-run single payer system and ban Corporate Alliances altogether; and
- The erosion of ERISA protection to maintain uniform benefit packages.

As you can see from the many disincentives, the economics of forming a **Corporate Alliance would not be feasible** for retailing companies and most other companies. Since a Corporate Alliance is not feasible for most employers, their employees will be required to change health care plans, possibly changing personal doctors, and lose the support their employers provide in the efficient plan administration and claim problem solving between third parties. The funding of the Health Security Act will also be affected since the estimated \$24 billion raised from the 1% payroll tax on Corporate Alliances will not be collected if most employers do not form a Corporate Alliance.

The Administration also states that business is merely being asked to contribute their fair share of 7.9% of payroll if they join a Regional Alliance. Nevertheless, the Health Security Act as proposed, would require any company otherwise eligible to become a Corporate Alliance but which elects to join a Regional Alliance to transition through an eight year phase-in before receiving the benefit of the 7.9% payroll cap. This would result in significantly higher than 7.9% of payroll cost for many employers in low-wage, labor intensive businesses such as retailing. Without immediately receiving the benefit of the full 7.9% payroll cap, employers would have no choice but to eliminate even more jobs due to the additional cost burden through the eight year phase-in.

A survey of ten retailers employing 1.3 million employees shows that for these companies the first four years of health care costs could rise an **average of 89 percent per year or higher** until the 7.9 percent cap is fully phased in after eight years.⁴ Even at the end of the phase-in period, the cost increase would be in **excess of 40 percent** for retailers joining a Regional Alliance. For retail employers choosing to form Corporate Alliances, costs would increase by an average of 98 percent, with several seeing increases in the range of 100 to 190 percent.⁵

Productivity data underscores why the Administration's plan would have disastrous consequences for the retail industry. On an annual basis, a full-time equivalent retail employee produces \$1740 in corporate earnings while a full-time manufacturing employee produces \$6447 in corporate earnings. Thus, on average, it takes more than 3.7 retail employees to equal the productivity of a single manufacturing employee, as derived from the chart below.

⁴ This mandatory phase-in applies even if those employers eligible to create a Corporate Alliance immediately join a Regional Alliance.

⁵ The survey was conducted by the National Retail Federation in conjunction with Towers Perrin, an independent employee benefits actuarial firm.

**PRODUCTIVITY AND HEALTH CARE COSTS
IN RETAILING COMPARED WITH MANUFACTURING**

	Annual Corporate Earnings Per FTE ⁶	Employer Cost of Individual Health Care ⁷	Cost of Individual Coverage of % of Earnings ⁸	Employer Cost of Family Health Care ⁹	Cost of Family Coverage as % of Earnings ¹⁰
Retailing	\$1,740	\$1440	82.8%	\$2240-\$3360	128.7%-193.1%
Manufacturing	\$6,447	\$1440	22.3%	\$2240-\$3360	34.7%-52.1%

Under the Administration's health care plan, employers would pay 80 percent of the premium cost of \$1800 per year for single coverage. That cost would be \$1440, or 83 percent of what a full-time retail employee produces in earnings. Eighty percent of family coverage, at \$4200 per year, would cost between \$2240 and \$3360¹¹ -- up to nearly double what a full-time retail employee produces in earnings.

Significant differences exist among industries in the contribution to company earnings by full-time equivalent employees. The labor-intensive retail industry, with its narrow profit margins and wage base, would be forced to absorb an imbalanced and disproportionately high percentage of the total expenditures required to finance the Administration plan.

Of all the major industries, the retail sector would experience the greatest percentage increase in the number of workers who would become insured by their own employer under an employer mandate.¹²

A recent study conducted by Lewin-VHI reveals that, compared to other industries, the retail industry would experience by far the sharpest increases in health spending under the Health Security Act.¹³ The table below illustrates the disparate impact the Act would have on the retail industry.

⁶ Source: "Survey of Current Business," Aug. 1993, Bur. of Economic Analysis, U.S. Dept. of Commerce. \$6,447 company earnings per full-time equivalent manufacturing employee/\$1,740 company earnings per full-time equivalent retail employee = 3.7:1.

⁷ Employers would be required to pay 80% of the Administration's individual coverage of the \$1800 per year, or \$1440. After the payroll cap is phased-in, employers electing to join a Regional Alliance but eligible for a Corporate Alliance, would pay \$1375 based on 7.9% of average retail worker earnings.

⁸ \$1440 employer cost/\$1740 company earnings per full-time equivalent = 82.8%
\$1440 employer cost /\$6447 company earnings per full-time equivalent = 22.3%

⁹ Family coverage would cost 80% of \$4200 per year, or \$3360. Regional Alliance employers would have their contribution prorated. If there were 1.5 working family members on average, the calculation would be: 80% x \$4200/1.5 = \$2240.

¹⁰ **Retail:**
Calculation with 1.5 family members per family in a Regional Alliance:
\$3360 employer cost/\$1740 company earnings per full-time equivalent/1.5 working family members per family = 128.7%.
\$3360 employer cost/\$1740/company earnings per full-time equivalent = 193.1.
Manufacturing:
Calculation with 1.5 family members per family in a Regional Alliance:
\$3360 employer cost/\$6447 company earnings per full-time equivalent/1.5 working family members per family = 34.7%.
\$3360 employer cost/\$6447 company earnings per full-time equivalent = 52.1%.

¹¹ See Footnote 9.

¹² Source: Sheila Zedlewski, "Expanding the Employer-Provided Health Insurance System: Effects on Workers and Their Employers." Health Benefits and the Workforce 1992.

¹³ Lewin-VHI, Inc. The Financial Impact of the Health Security Act (Dec. 9, 1993).

**NET CHANGE IN HEALTH SPENDING FOR PRIVATE FIRMS
IN SPECIFIC INDUSTRIES IN 1998¹⁴**

Industry	Net Change	Average Per Worker Increase
Construction	\$1.6 billion	\$243.00
Manufacturing	(\$2.1 billion)	(\$96.00)
Trans., Comm. Ut.	(\$4.3 billion)	(\$628.00)
Wholesale Trade	(\$0.7 billion)	(\$177.00)
Retail Trade	\$17.1 billion	\$1,167.00
Services	\$15.0 billion	\$576.00
Finance	\$0.8 billion	\$127.00
Other	\$1.5 billion	\$334.00
Total Private	\$28.9 billion	\$319.00

Lewin-VHI estimates that, by 1998, retail employers' health care costs would increase by an average of **\$1167 per worker**. When you compare this type of increased cost with the company earnings per full-time retail equivalent employee (\$1740), you begin to see the true imbalance of the additional cost burden on retail and other labor-intensive, low-wage industries. In comparison, the service and construction industries would experience an average per-worker increase of \$576 and \$243 respectively. Of the projected \$28.9 billion increase in health spending among private firms in 1998, the retail industry would bear 59% or **\$17.1 billion**.¹⁵ Obviously, the retail industry cannot absorb such a massive cost increase.

Employment Effects of the Administration's Proposed Employer Mandate

The public seems to understand better than the Administration the impact an employer mandate will have on jobs. According to a recent Washington Post poll, 64 percent of Americans are concerned that the Administration plan will cause employers to eliminate existing jobs.¹⁶ Likewise, economists agree that an employer mandate is a tax on employment which will reduce employment growth,¹⁷ especially in smaller firms and in low-wage, low profit-margins industries.

Other studies point out the inevitability of significant job losses if an employer mandate is enacted. One such study,¹⁸ points out that the key issue with employer mandates is their impact on labor costs:

"Labor costs drive the job loss. This is particularly true in low wage industries where wages are too low to permit shifting of the mandate's cost back to wages. Higher wages industries, on the other hand, can much more readily shift the increased costs back on to wages. When industries cannot shift this cost the inevitable result is the loss of jobs, with the job loss increasing with the unshiftable cost."

Robert Shapiro, Vice President of the Progressive Policy Institute, wrote in the New Democrat that "by most employers' calculations, the productivity of low-wage workers cannot justify health care coverage that would substantially raise their total compensation. Far from guaranteeing benefits to low-skilled workers, a rigid employer mandate, by the economics of it, would probably cost many of them their jobs."

¹⁴ Source: Lewin-VHI estimates using the Health Benefits Simulation Model.

¹⁵ Id at 76.

¹⁶ Washington Post poll of 1015 adults. 10/12/93.

¹⁷ Source: A USA Today/CNBC survey of 55 economists revealed that 78% fear that enactment of the plan would slow employment growth. USA Today/CNBC survey of 55 economists. 10/1/93.

¹⁸ Source: "The Impact of a Health Insurance Mandate on Labor Costs and Employment" conducted by the Center for the Study of Business and Government of the City University of New York.

Business Week's Bill Javetski, who covers European economic policy, notes the Administration's contention that there's a lot we can learn from the Germans whose national health program provides comprehensive coverage at a mere 9% of gross domestic product, compared with 14% in the U.S. Javetski points out: "But what the President isn't factoring in is the cost employers pay, on top of wages, to support the systems. In fact, across the European community, benefits costs - mostly for health insurance - are twice those in the U.S. The EC now admits that such costs are a big reason why the U.S. created 20 million jobs in the 1980s while Europe produced barely any." (Emphasis added)

Moreover, the foregoing analyses are consistent with the mainstream of economic thought. The University of New Hampshire surveyed members of the American Economics Association which is the leading professional body for American economists. Eighty percent of economists responded that a health care mandate would result in lost jobs for lower wage workers.

A leading Democratic Economist, Lester C. Thurow of the Massachusetts Institute of Technology's Sloan School of Management, is cited in the January 24, 1994 edition of Business Week as stating: "The Europeans have taught us that mandated benefits end up pricing labor out." (Emphasis added)

The job loss concerns raised above are consistent with extensive analysis by Montgomery Ward undertaken in conjunction with nationally recognized benefit consulting firms. In my view, the analysis of other management in labor-intensive, highly-competitive, low-wage industries such as retailing would be similar.

The retail industry acts as a safety net of sorts to provide gainful employment to workers of other industries who lose their jobs. When retail jobs are lost, many of these workers will have no industry to which to move to obtain gainful employment.

An employer mandate affords management virtually no choice. We truly want to grow jobs and the business. However, to continue to run a viable business, cost would have to be taken out. The largest cost in labor intensive industries is obviously labor. We would have to closely analyze our store and support operations to determine where such costs might be reduced. This is a very painful process which I had to undertake once before. When I joined Montgomery Ward in the mid 1980s, I encountered an excessive cost structure which caused the company to face potential liquidation. Had we not eliminated 17,000 jobs to save 60,000 other jobs, Montgomery Ward would not be in business today.

A cost analysis of store and support operations would generate a prioritized value of each job to the company. We would have to take the risk of adversely affecting operations and customer service and eliminate a number of these jobs. Unfortunately, a health care employer mandate is so massive in its cost impact that the actions described above would not be sufficient. Due to the increased costs of the mandate, many of our currently viable stores would operate at a loss and would have to be closed, as would a number of our distribution facilities and warehouse. Other formerly profitable operations would be come marginal and entail further painful decisions. The truly tragic irony is that the very people government is trying to help through the employer mandate would, because of this terribly misguided but well-intentioned approach, suffer the loss of something far more valuable to them and their families, namely, the loss of their livelihood.

In addition to the excessive cost of the mandated benefits discussed above, the Administration's plan imposes additional substantial administrative costs that provide no benefit to health care consumers. The plan requires complex data collection, reporting and proration requirements that will especially burden employers in multiple states or those with part-time and seasonal workers. The complexity of the proposed plan should not be underestimated. Each state may have several regional alliances with different premium pricing. A company like

Montgomery Ward which has operations in 40 states will have to accumulate and report member coverage data, calculate and transmit individual Regional Alliance premiums, prorate premiums, and collect employee shares of premiums for potentially over 100 Regional Alliances each month. Also, because of employee turnover, Montgomery Ward with 60,000 employees may employ as many as 175,000 workers each year. This means we handle three times the administrative burden as the number of currently working employees. These turnover percentages would be similar for other retail businesses. This truly awesome administrative process would be required for 20 million workers in the retail industry. For many companies, this will entail significant expenditures in programming and updating or replacing current payroll systems. Additionally, where employees elect coverage in their spouse's plan, we will need to calculate, collect, report and transmit premiums to each Corporate Alliance elected by any of our employees.

Moreover, a major concern of retailers and other businesses with operations on a multi-state basis is the Federal ERISA preemption. This preemption permits multi-state businesses to operate their health care plans under Federal law without being required to comply with widely varying legislation and regulations of a number of different states. Compliance with a diverse set of state by state plans would be extremely inefficient, expensive and burdensome. We urge Congress to resist weakening the ERISA preemption or granting waivers to individual states.

It is overly simplistic to believe that retailers raise consumer prices in order to cover these massive cost increase. Many retail purchases are discretionary in nature and deferrable. Also, due to intense competition, major segments of the retail industry are experiencing price deflation in many merchandise categories. Increased prices typically will decrease the demand for these products. Our experience is that customers will do without if they feel prices are too high. In the current low-margin retail industry, we simply cannot pass higher prices on to consumers.

Thus, most retailers will have no choice but to cut jobs or reduce workers' hours in order to meet increased costs. In the long run, the burden of this cost increase would fall on workers. Part-time and low-wage employees have less opportunity to trade wages for health benefits, but are the most likely to feel the effects of an employer mandate through a combination of job loss, reduced wages and/or hours, and foregone salary increases.

As stated earlier in the Arthur Andersen study, customer traffic patterns vary significantly during the business day. At Montgomery Ward and many other retailers, over 75% of the available work hours fall between 2 p.m and 9 p.m. on Monday through Friday and on weekends. Were retailers to shift part-time jobs to full-time positions, full-time employees would be required to work the majority of their weekly schedule during evening hours and on weekends. In order to match full-time scheduling to customer buying patterns, some employees would be required to split their work day into two pieces with morning and evening hours. This forced scheduling of full-time employees to meet our customer needs would, in many cases, cause significant life style changes, including child care scheduling problems. Also, a portion of the retail full-time workforce would undoubtedly be forced to leave their jobs due to incompatible work schedules.

As indicated earlier, **73 percent of part-time employees choose to work part-time.** Workers want and need the flexible opportunities part-time employment

offers. Many work out of necessity to supplement family income and, contrary to popular belief, the majority of part-time retail employees have health insurance.¹⁹ The Administration plan, although well-intentioned, will not benefit these workers, and could very well cost them the jobs they need to make ends meet.

When is the Cure Worse Than the Disease?

Our nation's health care system is truly massive and complex. The economic and social implications of health care reform exceed those of virtually any other issue. Your decisions will dramatically affect not only the \$900 billion per year health care industry, but the \$2 trillion per year retail industry, other labor-intensive industries and every remaining segment of business. Of equal, if not greater, importance is the unique value placed by Americans on the quality and nature of the health care they receive.

We support the goal of coverage for all Americans. Problems in our health care system need to be addressed. Specific focus upon the uninsured, cost control, efficiency, small market reform and insurance reform can result in sensible solutions to problems in these areas. Solutions in health care, however, cannot be achieved at the cost of jobs in labor-intensive industries and our nation's economic vitality. We urge you not to ignore the dire warnings of business people throughout retailing and other labor-intensive industries and leading economists as to disastrous effects of an employer mandate on jobs and our economy. Such a mandate, if enacted, would:

- Tragically cause many of those individuals most in need of health care coverage to lose something they and their families need and cherish far more -- their means of earning a livelihood.
- Devastate labor-intensive industries -- the retail industry which employs 20 million workers (one in five) would, under the Administration's employer mandate, be faced with a cost increase of \$17.1 billion out of the projected \$28.9 billion increase in health care spending in 1998 among businesses. Employers would have no choice but to dramatically reduce labor costs, i.e. jobs, to stay in business.
- Result in serious adverse impact on jobs and the economy, according to numerous economic authorities, including leading Democratic Economist, Dr. Lester C. Thurow of M.I.T., who have analyzed the impact of an employer mandate on the U.S. economy in light of experience in the European community and elsewhere.
- Effectively remove from businesses the capability to control health care costs. In my opinion few businesses would find it advantageous to continue their own health care plan under the Administration bill.
- Stifle creative approaches and the careful expenditure of health care dollars by individuals and business. With no ability to reduce costs (a mandate fixes costs), business will have no incentive to explore methods of doing so.
- Wreak havoc causing massive job loss and severely damage our economy.

As an employer who views with pride our historical legacy as the first American company to offer health care coverage to our employees in 1912, and as a concerned industry, we want to continue to meet the needs of our workers and the consumers we serve. We look forward to working with Congress to achieve the goal of universal coverage while addressing the critical issues raised today.

¹⁹ Recent studies show that approximately 50 percent of part-time retail workers currently receive health insurance coverage under a family member's or spouse's insurance plan. Also, many part-time retail employees hold full-time positions in other fields (such as teaching) and receive health coverage through their full-time employer.

Mr. GIBBONS [presiding]. Mr. Patricelli.

STATEMENT OF ROBERT E. PATRICELLI, CHAIRMAN, HEALTH AND EMPLOYEE BENEFITS COMMITTEE, U.S. CHAMBER OF COMMERCE, AND CHAIRMAN AND CHIEF EXECUTIVE OFFICER, VALUE HEALTH, INC., AVON, CONN.

Mr. PATRICELLI. Good morning, Mr. Gibbons, members of the committee, I am Robert E. Patricelli, chairman of the U.S. Chamber of Commerce's Health and Employee Benefits Committee and a member of the board of directors of the U.S. Chamber. I am also chairman and chief executive officer of Value Health, Inc., of Avon, Conn.

Sometime yesterday my written statement was submitted to this committee to meet its time requirements, but that statement had not been reviewed by me and was inadvertently sent to the committee by Chambers' staff and does not accurately reflect the position of the Chamber on health care reform.

Mr. GIBBONS. Oh boy, I am glad I don't work for you.

Mr. PATRICELLI. I think several of the members seem to have colds.

I am here to give you the definitive, current position of the Chamber on health care reform, and I would like to note that the committee—to the committee that the full Health and Employee Benefits Committee of the Chamber, plus four other policy committees and the board of directors, will be reviewing that position in detail over the next 2 weeks prior to the review and decisions of the board.

I will summarize this testimony in terms that I hope are very clear, and if I err on the side of bluntness, please understand it is because I am trying to be as clear as possible.

Mr. GIBBONS. That is all right; we like blunt people.

Mr. PATRICELLI. Well, I have five points, Mr. Chairman.

First, about 1 year ago the U.S. Chamber board adopted a preliminary set of guidelines for health care reform. Those guidelines supported the goal of universal coverage and that has not changed.

Second, in that set of guidelines we expressed the view that, "provided the minimum benefit package is not defined to be overly expensive, all individuals should be required to have health insurance, which should be paid for through a combination of: public funding for the elderly, poor, and near poor; employer-employee contributions for all working people and dependents; and individual contributions." We have consistently since interpreted that board policy as requiring a system of shared responsibility among employers, individuals, and government for the funding of health insurance.

Third, we have not yet seen any bill which we feel strikes anything like a proper balance of responsibilities among the potential funding parties. Specifically, we cannot support any of the mandate proposals that have been advanced in legislation by President Clinton or Members of Congress.

Fourth, we specifically cannot support the President's Health Security Act. While that bill has some good elements, it proposes such a burden of high employer premium contributions, rich benefits, counterproductive regulation, and new Federal and health alliance

bureaucracy, that we believe that it cannot even be used as a starting point for committee markup.

Fifth, and last, we are currently reexamining in our committee process whether there are alternatives to reaching universal coverage beyond employer or individual mandates or single-payer systems, which we certainly oppose. This reexamination has been forced by what seems to us to be the tendency of the political process to so encumber mandates with excessive costs, price controls and bureaucracy that what might seem theoretically acceptable becomes unsustainable in practice. The Clinton bill, for one, certainly gives mandates a bad name. If employer mandates become the vehicle for those who favor the trappings of a government-dominated system, we will not accept those mandates.

Mr. Chairman, the U.S. Chamber supports health care reform that will progress this country to universal coverage over time, at an acceptable cost, and which is based upon a private market-based approach to cost containment; and we stand ready to assist the committee in meeting that goal.

Mr. GIBBONS. Thank you.

[The prepared statement follows:]

STATEMENT
on
EMPLOYER RESPONSIBILITY IN HEALTH CARE REFORM
before the
COMMITTEE ON WAYS AND MEANS
for the
U.S. CHAMBER OF COMMERCE
by
Robert E. Patricelli
February 3, 1994

Good morning Mr. Chairman and members of the Committee. Sometime yesterday, my written statement was submitted to this Committee to meet its time requirements. That statement was not reviewed by me and was inadvertently sent to the Committee by Chamber staff and does not accurately reflect the position of the Chamber on health-care reform. As the Chairman of the Health and Employee Benefits Committee of the U.S. Chamber and a member of its Board of Directors, I am here to give you the definitive current position of the Chamber on health-care reform. I would also like to note to the Committee that the full Health and Employee Benefits Committee of the Chamber, plus four other policy committees, will be reviewing our position in considerable detail over the next two weeks prior to the review and decisions by our Board of Directors at its meeting on February 28.

I want to summarize my testimony in terms that I hope will be very clear to this committee, because the subject of this hearing—universal coverage and employer mandates—is absolutely central to the health care reform debate. If I err on the side of bluntness, please understand that it is because I am trying to be as clear as possible.

First, about one year ago the U.S. Chamber Board of Directors adopted a preliminary set of Guidelines for Health Care Reform. Those guidelines supported the goal of universal coverage, and that has not changed.

Second, in that set of Guidelines we expressed the view, and I quote, that "provided the minimum benefit package is not defined to be overly expensive, all individuals should be required to have health insurance, which should be paid for through a combination of:

public funding for the elderly, poor and near poor; employer/employee contributions for all working people and dependents; and individual contributions." We have consistently since interpreted that Board policy as requiring a system of shared responsibility among employers, individuals, and government for the funding of health insurance.

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Fifth, we are currently re-examining in our committee process whether there are alternatives to reaching universal coverage beyond employer or individual mandates, or single payor systems (which we certainly oppose). This re-examination has been forced by what seems to us to be the tendency of the political process to so encumber mandates with excessive costs, price controls and bureaucracy that what might seem theoretically acceptable becomes unsustainable in practice. The Clinton bill, for one, certainly gives mandates a bad name. If employer mandates become the vehicle for those who favor the trappings of a government dominated system, we will not accept those mandates.

Mr. Chairman, the U.S. Chamber supports health care reform that will progress this country to universal coverage, over time, at an acceptable cost, and which is based upon a private market-based approach to cost containment. We stand ready to assist the Committee in reaching this goal.

Mr. GIBBONS. Let me say before I go to the next witness, staff informs me that the chairman started and did not give, because of the confusion that was around here, members a chance to make their opening statements, and I understand that Mr. Archer and Mr. Stark and Mr. Thomas all have statements. So let us go to that right now.

Mr. Archer, would you like to make your opening statements.

Mr. ARCHER. Thank you, Mr. Chairman. I regret that we had a vote on the floor of the House that pulled us away at the beginning of this hearing.

I join in welcoming our guests this morning to receive additional testimony on the most critical part of the Clinton health plan, and that the mandate on every employer to pay for government-sanctioned health insurance to all employees.

The employer mandate is the most significant, far-reaching, and potentially damaging element of the President's health reform plan. And I believe Congress needs to analyze the employer mandate more crucially than any issue that it has debated in many, many years.

To date, the evidence presented to the committee has weighed against the mandate. Recently, we received testimony from an ideologically diverse group of economists who all agreed that the cost of mandated coverage is actually borne by the employees, not the employers.

Now we have an analysis by the Joint Tax Committee making similar conclusions. An employer mandate is like a tax on income, it lowers employees' salaries and wages by the amount of the total insurance premium. For hourly workers, it reduces the incentive to work, and for minimum wage workers, it may very well mean the loss of their jobs.

The President's plan is also no champion of the family with two workers. The premium structure imposes a significant implicit tax on the second worker. In addition, the calculation of the family premium is so complex that the administrative cost of family coverage will be significant.

Ironically, at the time the President's plan imposes new burdens on business, it will strip the employer of control over health care costs. Containing costs will become the job of the government's bureaucrats using price controls. So instead of companies trying to preserve wages and profits by holding down insurance costs, we will have to rely on Washington to do the job.

I do hope we do not impose these burdensome requirements on business. That could have serious consequences for workers and for our economy, and I look forward to today's testimony.

Thank you, Mr. Chairman.

Mr. GIBBONS. Good. Thank you, Mr. Archer.

Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

The committee is going to focus on the economic impact of an employer mandate as proposed by the President in H.R. 3600, the administration's Health Security Act.

As he outlined for us in the State of the Union address, he has a bottom line and that is universal coverage. And I suspect you will

hear a lot of testimony today that suggests that our witnesses concur that there should be universal coverage.

As has been so eloquently pointed out by Ira Magaziner, we all have access to the best restaurants of the District, but precious few of the residents of the District of Columbia can afford to buy the meals. And that is the problem we have with many of our uninsured today. It is available; it is just available at costs that are unattainable by the average American.

The President's plan includes subsidies to help some of these low-income individuals and, indeed, some small businesses to achieve these goals.

I would point out that in Hawaii where there is an employer mandate, the Governor said that any business that can show it will go out of business because of the burden of the universal mandate, we will pay their health insurance. They put up a million dollar fund, and in 10 years only \$100,000 of that fund has been spent. The Governor said he is making more money on interest on that fund than he is losing by businesses that cannot make the mandate.

So there is a burden of proof on businesses, in some reasonable amount, to show that the business is so ineptly run and it is so marginal in its existence that it cannot afford a small amount to pay a minimum benefit in health insurance.

These goals of coverage and access are linked. To achieve universal coverage, every resident must have a nationally guaranteed health insurance coverage plan. They may buy it from Blue Cross; they may get it from the Federal Government, but just to improve the availability through private markets, with or without alliances, is not the answer. We must have everyone guaranteed with that coverage.

I endorse the President's goals, and I agree it may be best to ask individuals and employers to share the responsibility of payments in the absence of public support for broad-based financing. While many of us might prefer a more progressively financed single-payer system in the interim, I can recognize the merit of building on the strengths of our current employer-based system, which works well for 150 million Americans.

I do not agree with every aspect of the employer mandate as proposed in H.R. 3600. I am not sure that virtually every employer and every individual should be required to disrupt their current health arrangement by forging a relationship with new regional alliances or forming corporate alliances.

I have not heard yet from a single employer who has come in and asked for these alliances. I would be interested in whether the witnesses want mandatory alliances. Employees have not asked us for those alliances either. As a rule, this committee operates under the edict, "If it ain't broke, don't fix it."

There are 37 million without insurance and it is going to cost about \$2,000 a year to insure them, and that is \$70 billion a year. How do we pay for it? If you truly believe everybody should have health insurance, there is your problem. Let us not hear you tell how you do not want to pay for it; how do you propose to chip in, and what is your fair share of how we raise that money?

Thank you, Mr. Chairman.

Mr. GIBBONS. OK.

Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

I, too, join my colleagues in welcoming today's witnesses who will help us once again explore the employer mandate. The one included in the President's health care reform proposal, a proposal which we now know, pretty obviously, is not without its competitors.

As we go through the major issues, I hope this committee will fully discuss alternatives to the President's plan to see how they measure up to our critical concerns regarding job loss, increased bureaucracy and income redistribution.

Given the schedule established by both the Health Subcommittee and the full committee for appointing a comprehensive bill, I believe it is important to analyze all of the health care reform alternatives at every opportunity.

Along with others, I have major concerns with the employer mandate included in the President's health care reform plan. During last year's hearings, and obviously as we begin again today, both the Subcommittee on Health and the full committee heard, and are hearing testimony, from a variety of business leaders, consumers and economists regarding who would really bear the cost of a mandate placed on employers to pay a portion of their employees' health care premiums as proposed by the President.

It was made clear and is being made clear that the added cost over time would be actually borne by the employees. The fact is substantiated by what was happening in the work force during the period 1970 to 1990, the real growth of the fringe benefit era. Total compensation wages plus fringe benefits rose 12 percent after adjustment for inflation. During the same period, inflation-adjusted wages fell by 6 percent.

We should not try to fool ourselves, or the American worker, by shifting the cost of health care premiums onto the employer. The fact is the employee ends up paying anyway through lower earnings over the long run.

I am very much concerned about the new bureaucracy that would be established in the Department of Labor to enforce the requirements placed on employers under the regional alliances in the three administered corporate alliances. This new bureaucracy would cost the American taxpayers billions and billions, by the administration's own testimony, and it is completely unnecessary.

Instead, this committee should look at using existing Federal structures, such as the Internal Revenue Service, to enforce a mandate on individuals and not add to the Federal bureaucracy, which the Vice President is trying so hard to reinvent.

Finally, Mr. Chairman, I am concerned about the job loss that would be caused by the employer mandates included in the President's plan. The record and subcommittee and full committee, and as my ranking member clearly indicated, the recently released Joint Tax Committee study, clearly shows that not only would you have increased costs imposed on businesses, but small businesses and industries, which hire low-wage workers, retail, service, agriculture, as we have already heard, would be hardest hit by the

mandate, displacing millions of workers, and, at the very least, the churning would be damaging to the economy.

The bill I introduced in November, along with Senator Chafee, H.R. 3704, achieves the President's goal of universal coverage, but through an individual mandate and subsidies to individuals and families with incomes up to 240 percent of the poverty level, when we prove savings. The individual mandate and subsidy avoids the negative effects I have outlined regarding employer mandates while retaining more individual choice over insurance and health care decisions.

I look forward to today's testimony and the continuation of today's testimony as we struggle with the question of how to provide universal coverage without endangering the health of our economy or charging the taxpayers for an unnecessarily enlarged Federal bureaucracy. And I look forward to the witnesses comments, especially the representative from the Chamber of Commerce, on H.R. 3704 and the way in which it proposes to go about providing universal coverage, and I thank the chairman.

Mr. GIBBONS. All right.

Well, you know, I had not been prepared to make a statement here, so I will make one off the cuff, and I will be like Mr. Patricelli, maybe it is a little rough. But we have been fooling with this system for 50 years that I know of and what have we got? We have got the most expensive health care system on earth and not the best. We have got a system that if you can tell me who pays for it, you are a genius, because none of us really understands who pays for it.

Everybody in America gets some health care. Some get it on a timely basis, and some get it awfully late. As we wander around our districts, we run into one horror story after another about the unfairness of the current system and about the expense of the current system.

Now, as I say, we have the most expensive system on earth. We far outrank anybody else as far as expense is concerned. As far as dissatisfaction is concerned, there are no people on earth that I know of, and I have traveled quite a bit at the taxpayers' expense, that are as dissatisfied with their system as Americans are.

Now, we have to do something about it. We have to bring down costs and we have to open up access and we have to get people out of job lock that is caused by the current system. Now, nobody wants to pay for it. Mr. Brennan's clients would rather that somebody else, maybe the steel workers or the Federal Government or somebody else, pay for it than their employees and their business.

I go to all the retail stores. I talk to the clerks. I find most of them have a primary job someplace else and they are getting their health care system through their primary job and they are working for Mr. Brennan at sort of a cut-rate business. Or their spouses have health care or they are already on Medicare, so his folks are kind of taken care of, and he would like to keep it that way. I don't blame him.

I know Mr. Patricelli's people, because I have been a member of the Board of Directors and the Board of Governors and everything else in my local Chamber of Commerce, and I know his people. I know small business people who, when they are hiring somebody,

they find out, first of all, whether the person is married, whether their spouse has health care insurance that covers them, and then they begin to talk to them seriously about a job.

That is perfectly legitimate under the current system, but unless you—nobody really knows who pays for the current system. We all know it is the most expensive on earth and we have to do something about it. And perhaps as far as an industrialized society is concerned, it is probably one of the most unfair systems.

So I cannot blame you for not wanting to pay for mandates. I have taken that position before in public statements, but somebody has to pay for it. The fairest way would be to pay taxes for it, but if I mention that to Mr. Archer, he will go through the roof here. He and many members of this committee do not think you can levy any kind of tax that is fair or right or just, and we are going to pay for it that way. So we have a real dilemma.

I appreciate you fine taxpayers coming here this morning to help us solve it, but as you leave this room, remember, we are going to try to solve that thing this year. There is going to be some awful unpleasant biting of the apple here this year. There will be votes this year. We have avoided them for 50 years, but we will get down to voting on it this year. And you are either going to get mandates or you are going to get taxes or you are going to go on with the same foolish system we have that nobody knows who pays for it, and it is the most expensive system on earth, and it is probably one of the most unfair systems on earth as far as industrialized countries where our standard of living is concerned.

Mrs. JOHNSON. Mr. Chairman.

Mr. GIBBONS. I had not planned to make that long statement but I thought I ought to get it off my chest.

Mrs. JOHNSON. Mr. Chairman, I would like to make a very brief opening statement.

Mr. GIBBONS. All right, as long as it does not take you longer than mine did, you are entitled to. Go right ahead.

Mrs. JOHNSON. This is a very important hearing. It is one I have been looking forward to. It is central to the issue of how we resolve our health care problems. But as we discuss the mandate, we have to remember that it is rising costs that have brought on this crisis. I am sure you will discuss the employer mandate in the context of its impact on jobs and the vitality of our economy. But I hope you will also discuss the employer mandate in the context of this society's ability to control health care costs.

I want specifically to understand from you whether there is a difference in the way employers will participate in cost control under today's system where employers choose the plan and under the President's system where the employers pay a payroll tax. If we do not understand how the private sector will disengage from cost control—at least that is my estimate, and I am looking to you to either confirm or deny that—if we do not understand what will happen, to whom in our society has the responsibility and power to affect health care costs shifted, then we will not be able to make the right decision about how employers and everyone else ought to participate in the new health care system.

So I hope you will not talk only about jobs and the vitality of our economy, which of course are terribly important to all of us, but

fundamentally how a payroll tax system would alter or change the way employers participate in meeting the challenge of health care cost control.

Second, I hope that some of you are familiar with a bill I introduced right before we adjourned in November, which proposes voluntary competing purchasing cooperatives which would, I think, provide a very rich and desirable alternative to some of the proposals on the table. Thank you.

Mr. GIBBONS. Yes, sir, Mr. Hoagland.

Mr. HOAGLAND. Mr. Chairman, I just have a brief statement. I would like to hear the witnesses address the issue of how we can achieve insurance reform without a mandate of some sort. I think most members are in strong favor of solving the portability problems that Americans face so they can have policies they can take from job to job and place to place, but can we do that without bringing everyone into the system? Can we do that without an employer mandate or an individual mandate or some combination? And, if so, I would be interested in hearing the views of the witnesses.

Thank you, Mr. Chairman.

Mr. GIBBONS. I don't want to abuse the committee's time, but does anybody else want to make a statement?

Mr. McDERMOTT. Mr. Chairman.

Mr. GIBBONS. Yes, Mr. McDermott, sponsor of a principal health care bill.

Go ahead.

Mr. McDERMOTT. With regards to the alternative you were mentioning, if business does not want employer mandates, as the President does, the single-payer plan is the only one that achieves universal coverage.

Mr. THOMAS. Would the gentleman yield?

Mr. McDERMOTT. No, not just at the moment.

Mr. GIBBONS. He just got started, Bill.

Mr. McDERMOTT. The fact is the single-payer plan is the only plan that has been evaluated by CBO; it is the only one with costs in hard numbers; it is the only one before the Joint Tax Committee; and it covers everybody in the country, with a more generous benefit package than anybody else is proposing. And the fact is the single-payer system has been used in every country of the world.

What is fascinating to me is the retailers, and now the Chamber of Commerce, are getting up here and begin by saying that America cannot do what they can do in every other industrialized country in the world. That is a terrible admission, and I would like to hear these people talk about why it is America is so weak and so uncreative that the business community cannot find any way to participate in a mandatory way as they do in every other country in the world. I think that is the question that is really before this Congress.

Are we going to let the business community walk out of here and say, "We will provide access"? Mr. Stark uses my line, or at least I have used it another way: I have access to every Mercedes dealer in Seattle. I don't drive a Mercedes because I don't have the money. Everybody who does not have health insurance has access today.

You are not giving them one thing when you give them access. So the question is how do you get coverage?

The President drew the proper line in the sand and I think that will be the standard. We are going to have to put something out of here that gives people coverage because we cannot say that we cannot do it when everybody else has done it, including France and Australia and countries that we think are not as advanced as we are. So I am really interested in what is the business community's responsibility in solving this problem.

Mr. SANTORUM. Mr. Chairman.

Mr. GIBBONS. I understand Mr. Bunning and Mr. Santorum want to make statements.

Mr. BUNNING. Thank you, Mr. Chairman. I was not going to make an opening statement, but since everybody else seems to be, I will try.

I want to comment on my good friend from Washington's comment about America. Whether we provide universal coverage like Great Britain or like Canada, visit those places and check out what kind of health care system they have and the effect that it has on their economy and the amount of dollars or the amount of their currency that goes into providing that kind of health care. I don't think the people in this country want that kind of system, and I sincerely believe that most people have spoken about what kind of coverage they like and what kind of coverage they want.

Eighty-five percent of the people in this country are very well satisfied with the quality of their health care system. Eighty-five percent. Now, we are going to make one-seventh of our economy change completely to accommodate 15 percent of those who are uncovered or dissatisfied completely with our health care system. I think we ought to look at that in proportion to what else we are trying to accomplish.

I don't think anyone here on this committee or in this audience or at the table testifying would like to deny people the ability to get coverage, and the gentleman from Montgomery Ward outlined those things. I think there is general agreement on both sides of this aisle, both sides of this committee, that we could pass a bill that would do those things that you have suggested tomorrow. The biggest problem we have is trying to take care of those who do not have the ability to take care of themselves, and I think that we should do that, but not disrupt and create more problems with the different types of bills that have been put in than we have under the current system.

So I would think that America has a great quality health care system, and I don't want the one that is in Great Britain. I don't want the one in Canada. I want to improve on the one we have here and allow access for those who cannot afford to have coverage.

Thank you, Mr. Chairman.

Mr. GIBBONS. Yes, sir. Now Mr. Santorum, and then if there are any others, I will be glad to listen to you and recognize you, but I want to say to please pick up this witness list we have here today, and I think all those who make these long statements should be prepared to stick around here because it is going to be a long, long day.

Mr. THOMAS. Mr. Chairman, parliamentary inquiry. Will we start a second round of opening statements?

Mr. GIBBONS. No. No, you have had yours.

Mr. Santorum.

Mr. SANTORUM. Mr. Chairman, like Mr. Bunning I was not prepared to make an opening statement, but I feel compelled to do so given some of the others.

All I can say is, I disagree with you, Mr. Chairman. I think we do have the best health care system in the world. We do spend a lot of money on it, but I don't know too many Americans who run to other countries to get health care, but I know a lot of people that come to this country to get health care. So I think we should feel very good about the quality of care given to the people in this country and we should not demean it.

In response to Mr. McDermott, I would just suggest that I commend these people, these gentlemen and this lady, for standing up here and saying they are not going to be sheep and follow to the slaughter a bunch of countries that have ruined their health care system with a government-run system, and I commend you for standing firm and trying to support a system that is going to work for America and that is not going to be a copy of programs that failed their citizens around the world.

I would just say that if access to Mercedes is your question, ask the people in Ontario in December whether access to their hospitals that were closed because they ran out of money was a problem. I would suggest to you that global budgets and that universal systems do not work in providing access to care if you are sick or if you need help immediately.

I would just commend the Chamber in its position of standing for universal coverage. In fact, I think, as Mr. Bunning just said, everyone here wants to make sure that every American has access to health insurance. And I hope we can work together and put aside some of the demagoguery that only one system universally ensures when, in fact, even universal systems have uninsured in it.

The fact of the matter is, we should all move together and try to do it in a sensible way where we can work cooperatively and not antagonistically.

Mr. GIBBONS. Are there any other members? Yes, sir.

Mr. HANCOCK. Mr. Chairman, I appreciate the comments that my friend from Washington made, except the first part, where he made the statement that the plan that he is advocating is the only plan that has actually been analyzed by the financial experts and CBO and come up with credible solid cost figures. I think I am correct in your statement; is that correct?

Mr. McDERMOTT. Yes.

Mr. HANCOCK. Well, I would like to ask this question, then. Here is the Small Business Administration's brochure on the President's plan. The question is, can we be confident that this plan has been analyzed rigorously and that the financing is reliable?

The answer from the President, the Small Business Administration, and Mrs. Clinton sitting testifying to this committee, here is the answer: Yes, at the very beginning of this process the President brought together some of the best minds in the country to help design the financing package for health care reform. The numbers

and analysis that underline the President's proposed plan for health security represents months of rigorous work by experts from various Federal agencies for the first time. An outside group of economists and actuaries audited the work that was done and examined and validated the costs and savings projections. These costs and savings projections are solid, credible and conservative.

Now, I would like to ask the gentleman from Washington the question——

Mr. GIBBONS. No, we are not going into that. We are using this opportunity——

Mr. HANCOCK. I would yield to the gentleman to reply.

Mr. GIBBONS. No, we are not going into that. You make an opening statement. If we do that, we will be here all night.

Mr. HANCOCK. Thank you, Mr. Chairman.

Mr. GIBBONS. OK, thank you.

Let's go to Mr. Pinkus.

STATEMENT OF DAVID PINKUS, PRESIDENT, SMALL BUSINESS UNITED OF TEXAS, ON BEHALF OF NATIONAL SMALL BUSINESS UNITED

Mr. PINKUS. Thank you, Mr. Chairman.

My name is David Pinkus and I am president of Small Business United of Texas. SBU is an active member of Small Business United where I have served on the Board of Trustees.

NSBU represents over 65,000 small businesses in all 50 States. For the last 4 years, health care reform has been our top Federal priority. Small businesses need and demand health care reform. NSBU is highly supportive of comprehensive health care reform that includes universal coverage. However, there are several ways to reach this goal and not all of them are good for small businesses and overall job growth. Today I would like to focus on the hardships that small business owners across the country face on a daily basis.

The First Lady said last year that the new health care plan could not be concerned with every undercapitalized business out there, but we are concerned about these businesses, and I am sure that you share that concern.

These businesses, after all, are the seeds of our future economic growth. I would like to share a real life example with you. I have a friend in Dallas, Tex., whose son, Kip, started a business restoring old cars in his garage several years ago. Last year, the business grew to two employees and moved into a small warehouse that my friend owns. Kip and his two employees are the beginning of a business which will succeed. Even though the business is operating, Kip has yet to take a salary out of his business and his father has collected no rent on the warehouse. Kip and his wife Debbie live on the salary she earns and on their savings.

If the business had to pay for health insurance for his two employees, even if the premiums were subsidized, the money would have to come from one of two places; either it would come out of the money that Debbie earns or out of the wages of the employees. While today I am talking about Kip, 90 or 100 years ago we could be talking about Henry, Henry Ford or Thomas, Thomas Edison, or any of the millions of other entrepreneurs that have preceded Kip

starting businesses in their garages in the quest for the American dream.

A Federal mandate to provide health insurance coverage would be the granddaddy of Federal mandates costlier and more burdensome than anything we have seen so far. If there had been an employer mandate for insurance, especially if combined with all the other Federal regulations and costs we see today, would we have a Ford Motor Co. or an Edison Electric today?

Health and Human Services Secretary Shalala has compared the individual mandate to a tax. Using the same logic, an employer mandate is also a tax. The employer mandate is a tax on employment that lowers wages, raises prices and generally hampers economic growth. Any employer-based mandate is essentially a payroll tax. There are no more damaging taxes to small businesses and their employees than payroll taxes.

The administration has made an attempt to deal with many of the complaints about the employer mandates with a subsidy for small businesses. These subsidies are elaborate, cumbersome, unequitable, and painfully expensive, and they do not address many of the larger burdens of the employer mandates such as the lack of flexibility in tight economic times or the needs of new and emerging businesses.

The subsidy plan sounds simple. In practice, this system is likely to be extraordinarily complex and expensive. Small businesses have no confidence that the capped percentages of payroll now being discussed will last over the long term. Your predecessors passed entitlement programs when they thought the money was available. In most cases, they dramatically underestimated future costs. Just look at Medicare and Social Security.

If there is to be a mandate for health insurance, we believe strongly that the mandate should fall on the individual. Lower-income individuals are more appropriately subsidized than are businesses that employ them, and an individual mandate would have little, if any, impact on business startup or expansion.

National Small Businesses United wants fundamental reform of the health care system. We believe such reform is critical to the long-term survival and growth of small businesses. However, we do not believe employer mandates should play a role in that system.

The world envies the ability of the United States to create jobs. Why should we become like everybody else in inhibiting the job creating capacity and imposing an employer mandate. Let's create an American system that serves the needy and builds upon the job creating flexibility of our competitive system. Thank you.

Mr. GIBBONS. Thank you, Mr. Pinkus.

[The prepared statement follows:]

Mr. Chairman:

My name is David Pinkus, and I am president of Small Business United of Texas. SBU of Texas is an active member of National Small Business United, where I have served on the Board of Trustees. Prior to the formation of SBU of Texas, I was a small business owner in Dallas. We at National Small Business United very much appreciate the opportunity to be here.

National Small Business United (NSBU) represents over 65,000 small businesses in all fifty states. Our association works with elected and administrative officials in Washington to improve the economic climate for small business growth and expansion. We have always worked on a bi-partisan and pro-active basis. In addition to individual small business owners, the membership of our association includes local, state, and regional small business associations across the country. For the last four years, health care reform has been our top federal priority.

I would like to emphasize this last point: small businesses need and demand health care reform. NSBU is highly supportive of comprehensive health care reform that includes universal coverage. However, there are several ways to reach this goal, and not all of them are good for small businesses and overall job growth. We will continue to speak out against approaches that harm small businesses, but this representation of our members should not be considered opposition to health care reform.

I. Introduction

Before going on, I would like to give you a picture of where NSBU is coming from on health care reform, in order to put our response into perspective.

Our position for ensuring that all Americans have health coverage has been consistent for almost three years: 1) require everyone to have coverage; 2) reform the insurance system so no one can be denied coverage; 3) institute a system of federal payments, based upon family income, so that everyone can afford coverage; and 4) control cost increases so that small businesses can afford coverage. It is a plan that responds to people, not to businesses; that responds to health care needs, not to employment status.

It is worth noting that NSBU agrees with the importance of all of the health care reform principles laid out by President Clinton during his presentation of the plan: security, simplicity, savings, choice, quality, and responsibility. We think that our own proposal encompasses all of these principles. In fact, we think that many items from our recommendations would actually heighten the adherence of the President's plan to these principles.

II. Obstacles Facing Small Businesses

During the course of the debate on health care reform you will hear numerous accounts (as you doubtless already have) of individuals and families have suffered severe hardships because of their lack of adequate health insurance. In his State of the Union

address, President Clinton spoke specifically about the Anderson family and their ultimate bankruptcy at the hands of the health care system. These are desperate problems that must be solved.

But there are also other hardships out there about which you will hear considerably less. Today, I would like to focus on the hardships that small business owners across the country face on a daily basis. To illustrate the gravity of the problems faced by small businesses, consider the ratio of business openings to closings. In 1991 (the most recent year for which the SBA has published statistics), 876,000 new businesses started, but in the same year, over 822,000 businesses closed. The U.S. now has more than 1 million more businesses with employees than it had at the start of the 1980s, but during that time, almost 9 million different businesses closed. To be sure, some of these business "closings" resulted from mergers or the shut-down of entities that were not "real" businesses to start with. Nevertheless, the extreme difficulty in keeping a business going is evident.

Unfortunately, the First Lady said last year that the new health care plan could not be concerned "with every under-capitalized business" out there. But we are very concerned about these businesses, and I am sure that you share that concern. These businesses, after all, are the seeds of our future economic growth.

I would like to share a real-life example with you. I have a friend in Dallas whose son, Kip, started a business restoring old cars in his garage several years ago. Last year, the business grew to two employees and moved into a small warehouse that my friend owns. Kip and his two employees are the beginning of a business which will succeed. In addition to restoring cars, they also ship hard-to-find parts all over the United States. Even though the business is operating, Kip has yet to take a salary out of the business, and his father has collected no rent on the warehouse. Kip and his wife Debbie live on the salary that she earns and on their savings.

If the business had to pay for health insurance for his two employees, even if the premiums were subsidized, the money would have to come from one of two places; either it would come out of the money Debbie earns or out of the wages of the employees. While today I am talking about Kip, 90 or 100 years ago, we could be talking about Henry or Tom--Ford and Edison--or any of the millions of other entrepreneurs that have preceded Kip, starting businesses in their garages in the quest for the American dream.

In 1951, my own father started a business. He bought a piece of land for \$1,000 and started a nursery and landscape company. Today, that company employs 250 people. For 20 years--until 1992--I helped run the company. On more than one occasion when my brother and I were struggling to figure out how to comply with one or more of the new regulations or legal problems that we, like most businesses, confronted on a daily basis, my father would listen and say, "If I had to start this business today, I couldn't do it."

III. The Employer Mandate

A federal mandate to provide health insurance coverage would be the granddaddy of federal mandates, costlier and more burdensome than anything we have seen so far.

If there had been an employer mandate for insurance--especially if combined with all of the other federal regulations and costs that we see today--would we have a Ford Motor Company or an Edison Electric today? I do not ask this question flippantly: will we have the companies of the future that will be needed to keep our people employed and maintain the economy and lifestyle that we want for our children?

Some may argue that the health care dollars that would come from an employer mandate are already being spent, so there would be no large net increase in health care spending for society. On these grounds, some people dismiss the potentially harmful economic effects of an employer mandate. But we must remember that not all avenues for raising revenues have the same economic effects. The same funds distributed in different ways can have profoundly different economic implications. For instance, Health and Human Services Secretary Donna Shalala has compared an individual mandate to a tax. Using the same logic, an employer mandate is also a tax, but these two taxes have very different real-world results. The individual mandate is a tax that can be eased through a direct subsidy, while the employer mandate is a tax on employment that lowers wages, raises prices, and generally hampers economic growth.

Any employer-based mandate is essentially a payroll tax. The Clinton plan makes that connection explicit by gearing premium levels to payroll levels for small employers. There are no more damaging taxes to small businesses and their employees than payroll taxes.

Of course, higher payroll taxes add to the cost of current employees, increasing incentives to lower wages and to reduce the numbers of employees. Of even greater importance is that these taxes would further raise the hurdle for starting a new business or for hiring an additional employee. The continuous flow of new business start-ups is one of the keys to the success of the U.S. economy. The total number of business start-ups must exceed the total number of failures in order to keep a growing small business community--and, as we discussed earlier--the gap between these groups is already perilously narrow. Unfortunately, payroll taxes are likely to increase the failures while making the start-ups more costly and difficult.

We should also remember that payroll taxes must be paid whether a business is currently profitable or not. Payroll taxes completely ignore the ability of a business or an individual to pay the taxes. A highly profitable business will pay the same as one struggling to meet payroll. And this, we feel, is perhaps the greatest problem posed by an employer mandate: its complete lack of flexibility.

A survey of the small business community sponsored by NSBU and Arthur Andersen's Enterprise Group last summer showed that small employers rely heavily upon adjustments in order to cope with health care cost increases, which averaged 22 percent in the previous year. In 1993, small business owners reported that they changed to policies with higher deductibles (31 percent), changed insurance companies (22 percent), changed to policies with higher copayments (19 percent), increased employees' contributions (17 percent) and reduced the covered benefits (15 percent). While none of these choices is pleasant, they represent the sacrifices made every day in America's small businesses to keep coverage available, to keep people employed, and to keep the business open and productive.

In small businesses these tough decisions are often made in concert with all concerned. We must remember that the relationships in small businesses are significantly different than those in larger companies, where there are those who have a stake in perpetuating an adversarial relationship between management and labor. Typically in small businesses, the owners and their employees—who are often family members and long-time friends—have a close working relationship. They know each other's families and share the joys and sorrows of life. And when tough business decisions must be made, such as scaling back insurance coverage, they are often made together, with great reluctance but with everyone's long-term benefit in mind.

Under the Clinton plan, small businesses and their employees will no longer have the option of purchasing less expensive insurance in bad economic times, even if the business is quickly losing money. Unfortunately, the major remaining areas of flexibility for the business will be wages and the jobs themselves. This problem is one more reason why we believe that the health care mandate should be severed from the work-place.

IV. The Small Business Subsidy

Admirably, the Clinton Administration has made an attempt to deal with many of the complaints about employer mandates through a subsidy for some small businesses. Unfortunately, the Clinton Administration's subsidies are elaborate, cumbersome, unequitable, and painfully expensive. And they do not even address many of the larger burdens of the employer mandate, such as the lack of flexibility in tight economic times or the needs of new and emerging businesses.

The subsidy plan sounds simple. Businesses with fewer than 75 full-time employees would have a cap on their health care costs of between 3.5 and 7.9 percent of payroll, depending upon its average size and the size of the business. In actual practice, this system is likely to be extraordinarily complex. But there are still many questions to which we do not know the answers.

First, the subsidies would stagger according to business size. Businesses with fewer than 25 full-time employees would get the most generous subsidy; those with 26-50 employees would receive a smaller subsidy; and those with 51-75 employees would receive still less. Businesses with more than 75 employees would receive no additional subsidy.

First, how and when is business size computed? The Clinton plan counts any employee who works more than 120 hours per month as full-time and any who works 40-120 hours per month as part-time. Employers would not be required to provide coverage for those working fewer than 40 hours per month. Of course, many businesses have employees who work greatly different hours each month. So, at the end of the year, businesses total up the number of employees who worked more than 120 hours each month, and take an average of all months in the year. From this average number of full-time employees, businesses would determine into which size category they fit and--thereby--what their subsidy rate would be.

But even once small businesses know the level of their premium caps, how do they calculate their average full-time wages, given that many employees will have fluctuated

from part-time to full-time during the course of the year? Do they somehow factor-in only those wages earned by employees during full-time months, proportionally? Once these employers know their payment rate for full-time employees, they must pay a *pro rata* share of that rate for full-time employees. Determining this payment will mean reviewing all records for the previous year and calculating the proportional payment on a month-by-month basis for each employee.

The significant point is that small business owners will be making these costly and time-consuming calculations *at the end of the year*. Businesses will have been making monthly payments to the health alliance--based upon what, we do not know--during the course of the year. They will calculate their premium caps at the end of the year and determine if they are due a refund. This system reflects a complete lack of understanding about how small businesses function.

If small business owners do not know up-front what they will be paying for health care, the subsidies will not have the desired effect. Both the complexity of the subsidy calculation and its placement at the end of the year contribute to this diffusion of the subsidy's impact. First, cash flow is a perennially big problem for small businesses--especially given the small business credit crunch--and paying the full-freight every month while hoping to get a refund check at year-end will create wage and job-loss effects similar to those that would occur in the absence of a subsidy. It is also difficult for a business to arrive at a fair price for its goods if it does not have a good handle on its input costs. Second, too many business owners might get caught-up in making some marginal employment decisions based upon their perceived subsidy situation--such as keeping some employees just below the full-time barrier near the end of the year to qualify as a smaller business. This sort of behavior is not good for businesses, for employees, or for the government. And it is certainly the wrong basis for making critical employment decisions.

So, how would we distribute subsidies differently? Unfortunately, we are only able to be critics of small business subsidies at this point. We can think of no way to equitably and effectively distribute health care subsidies to businesses. Do you subsidize the businesses that do not currently provide insurance? Tell that to their competitors who have been providing coverage and will receive no subsidy. Do you subsidize low-wage businesses--thereby encouraging low wages? Do you subsidize low-profit or low-revenue businesses? There are plenty of low-revenue businesses that are highly profitable, and there are plenty of ways to hide profits in order to collect federal dollars. Frankly, we are skeptical about whether there is a fair way to subsidize businesses for health insurance, which is just one more reason we have rejected an employer mandate as the appropriate avenue for universal coverage. And it is one more reason that we support health care subsidies for *individuals*, based upon their ability to pay.

V. Fear of Future Costs

Small businesses have no confidence that the capped percentages of payroll now being discussed will last over the long term. Your predecessors passed entitlement programs when they thought that the money was available. In most cases, they dramatically underestimated future costs. Just look at Medicare and Social Security. These programs now cost many times what they were projected to cost when they were

initiated. FICA taxes have had to escalate sharply from just a few points to today's 15 percent in order to keep up. Small businesses just do not believe that health care costs will stay in check, so they do not believe that the federal government could possibly afford to maintain the subsidy levels outlined in the Clinton plan. What happens then?

As a representative of small businesses, my job is to promote business and economic development. I work to involve my members in supporting legislation that helps businesses grow and create economic opportunity. When necessary, we work to oppose legislation that hurts business growth. If you pass an employer mandate and a small business subsidy, my job and the jobs of those like me will change dramatically. Within two years, you will begin analyzing the huge amounts of money being spent on small employer subsidies, and many of you will begin proposing to reduce the subsidies in order to reduce the deficit or meet higher-than-expected health care costs. I will then be spending my time panhandling for those subsidies because you will have made many small businesses dependent on a new entitlement and created one more special interest demanding its share of the federal pie.

VI. Individual Mandate

If there is to be a mandate for health insurance, we believe strongly that the mandate should fall on the individual. Lower income individuals are more appropriately subsidized than are the businesses that employ them, and an individual mandate would have little if any impact on business start-up or expansion.

Please understand where we are coming from: an individual approach is not an attempt by small business to duck responsibility for the health of their employees; over 80 percent of small business employees and their dependents have insurance. An individual mandate will not cause those businesses currently providing insurance to drop it. In fact, we think that requiring all individuals to participate in the system would actually increase the pressure that employees place on their employers to provide that coverage for them, causing employer-provided coverage to increase. Yet, there are situations where the added expense of health insurance would cause wage deflation, lost jobs, and even business closings. A system that responds to the needs of the employees and families of such businesses--on an individual basis--would be the best system. As important as it is to provide access to quality health care for all, we think that employment and jobs should receive equal attention, especially when there is a conflict between these two needs.

VII. Conclusion

National Small Business United wants fundamental reform of the health care system; we believe that such reform is critical to the long-term survival and growth of small businesses. However, we do not believe that an employer mandate should play a role in that new system. The new system must make economic sense, and it must take the unique needs of small businesses into account. We are not aware of a way to structure an employer mandate such that it accomplishes these two goals. Thank you for allowing us to participate in this hearing.

Mr. GIBBONS. Ms. Connerton.

STATEMENT OF PEGGY CONNERTON, DIRECTOR OF PUBLIC POLICY, SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO

Ms. CONNERTON. Thank you. My name is Peggy Connerton. I am the director of public policy for the Service Employees International Union. With over 1 million members, SEIU is the largest union representing service workers in the United States. The members of SEIU, some of whom are counted, unfortunately, among the 39 million uninsured Americans, welcome President Clinton's pledge to veto any legislation that does not guarantee universal coverage.

If we can agree for the moment that universal coverage is in fact the goal, the question becomes how to pay for it. Today we have a very complex system in which businesses pay for some of it, individuals pay another third of it, and the Federal Government and others through cross subsidies pay the rest.

Short of a totally tax-financed system, an employer mandate is, in our view, the only feasible way to guarantee universal coverage. You have heard some of the reasons. It is a system that Americans are familiar with, it builds on the current employer-based system, and it would reach 85 percent of those who are uninsured who live in families with at least one employed adult.

We know that the employer mandate will save money for the majority of employers that currently provide health insurance. Many of them are paying more than their fair share because they are covering the working spouses of the part-time employees at Montgomery Ward's and other companies, as well as paying extra surcharges on their hospital bills to pay for the uninsured.

Assuming no other cost controls go into effect, those employers would save 20 percent off their premium costs from removing dependents from their policies according to a 1991 NAM study. Small businesses providing health insurance, and we represent many of them, are among the biggest winners for all the reasons I have laid out in the written testimony.

There are also important economic reasons, and I want to talk a little bit about the serious distortions today in the labor market, particularly in the service sector, resulting from the growth of part-time and temporary employment.

The growth in part-time and temporary employment in industries that are highly competitive is directly related to the high cost of providing health insurance. If an employer can hire a part-time worker and avoid that cost, they will do so and that's what is in fact happening in many of the industries where we represent workers.

In the building service industry, for example, cleaning firms do not generally cover part-time workers, even when we ask them to in negotiations. At the same time, their work force is becoming more and more part-time.

In the hospital industry, where important care is being provided today, 40 percent of the work force is part-time or temporary. Our hospitals generally do not cover part-time workers, and not surprisingly, more and more of the hospital employees being hired today are part-time workers.

The current employer-based financing system is falling apart. It is falling apart in the service sector and again service industries, as you know, are the largest growing sector of the economy. There is going to be some talk today about massive job loss among service workers. However, as economists have said in previous testimony, in fact, health care is a fringe benefit and is part of the compensation package.

Though, in fact, it is true that the costs of health coverage are indeed borne by the worker, it is part of the compensation package. It is what we do in negotiations when we bargain over how much of the compensation package is going to go into wages and how much into health and other fringe benefits.

Now, the key point to make here is that because of the rapidly rising costs of health care in the last 10, 12 years, workers have had to really trade off wages, that is, accept less in wage increases than they would have otherwise. We published a study which shows that, in fact, real wages in the economy have declined because of this health care crisis.

So if you want to talk about wage losses or job losses, you need to look at the big economy-wide picture and see what is happening to the economy because we cannot control escalating health care costs.

Now, it is true that minimum wage workers, it is more difficult to have them pay, however, all of the recent evidence, and I invite people on this committee to examine the recent evidence on the increase in the minimum wage, which shows that, in fact, despite projections and you have all heard it, tens of millions of jobs will be lost because of the 90 cent increase in the minimum wage, in fact those job losses did not occur.

The only other alternative out there is a straight individual mandate. Now, the calculus is very simple as to what an individual mandate will mean. We know today that business today finances one-third of total health spending. If an individual mandate is imposed, everybody recognizes that large numbers of employers are going to drop coverage, particularly for lower-wage workers.

So you are not going to have that financing. That means that you are going to be asking the Federal Government to pay more and you are going to be asking individuals to pay more. That is the calculus.

For moderate-income families, those earning approximately \$30,000 a year, they could have to pay the entire family premium cost of \$5,000. Now, we do not think that this is the way to go. So now you have to look at the alternatives.

There is the tax alternative and the employer mandate. Finally, there is the individual mandate. The bottom line is that we believe requiring all employers to make some contribution to the cost of health coverage is the way to go.

Thank you.

Mr. GIBBONS. Thank you, ma'am.

[The prepared statement follows:]

**STATEMENT OF PEGGY CONNERTON
SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO, CLC**

My name is Peggy Connerton and I am the Director of Public Policy for the Service Employees International Union. With over one million service-sector members in the United States, Canada and Puerto Rico, SEIU is the fourth largest union in the AFL-CIO, and the largest union representing service workers.

SEIU members come from both the public and private sectors and include 450,000 health care workers who work in acute care hospitals, nursing homes, psychiatric hospitals and other health care facilities. On their behalf, I would like to thank Chairman Rostenkowski and the other members of the committee for this opportunity to testify on one of the most critical issues facing our nation today. Let me also take this opportunity to applaud the chairman for your outstanding leadership in this area over the years.

Our members don't need charts and graphs or expert pronouncements to understand that there is a crisis in our health care system. Our members have fought hard to hold on to their health insurance, often foregoing wage increases and improvements in other benefits to maintain coverage for themselves and their families. They have faced greater out-of-pocket costs and declining choices as employers have tried to restrict where and when they can see their family doctors.

While disagreements over health care issues have made collective bargaining more contentious than it otherwise would have been, labor and management have also worked together to pioneer new cost containment strategies, such as utilization review and managed care. While these measures showed some short-term success, they were unable to blunt the long-term rise in costs. Only system-wide reform can provide the relief that workers and their employers need.

I am here today to present our views on the employer mandate provisions of the Health Security Act. We feel that, short of a totally tax-financed social insurance system, an employer mandate is the only feasible way to provide health insurance coverage to all Americans.

There are three issues I want to address this morning. I want to restate why we believe that universal coverage must be at the center of any healthcare reform effort. I then want to discuss the advantages of using an employer mandate to achieve universal coverage. Finally, I want to point out some of the real benefits that the Health Security Act provides to employers, especially the majority who are already providing health insurance for their workers.

Universal Coverage

It should be a source of shame to us that in the richest nation on earth there are 39 million people without any form of health insurance whatsoever. As many as 50 million more are underinsured and often do not discover the crucial gaps in their health insurance

until it is too late. In addition to the high cost of health insurance, many individuals and families are denied coverage because their employer does not provide it or because of pre-existing conditions that the insurance company refuses to cover.

Even those with insurance are not secure. One out of every four Americans will lose their insurance at some point in the next two years. Many of our members report that employers have been trying to scale back their health insurance coverage or imposing greater restrictions on its use.

The members of the Service Employees International Union have long supported universal access to health care. President Clinton's plan would eliminate existing barriers to coverage and guarantee access to a comprehensive range of health care benefits. No one would be denied coverage because of their income, health or employment status.

The first argument for universal coverage is a moral one, a perspective that is often forgotten during the conversations among Washington's power elite. I think that the Catholic Bishops of the United States put it well when they wrote last summer that "health care is more than a commodity; it is a basic human right, an essential safeguard of human life and dignity." Access to care when we are sick should not depend on whether we are young or old, employed or unemployed, rich or poor.

There are also, however, strong economic arguments in favor of universal coverage. The existence of a large pool of uninsured individuals drives up health care costs for the rest of the population. It is well known that uninsured individuals are more likely to postpone needed primary and preventive care and wait until their condition becomes serious enough to warrant a trip to the emergency room. This is the most costly form of care imaginable.

The growing number of uninsured is also a particular burden to our nation's public health system, particularly public hospitals. SEIU members work in hospital emergency rooms across the country where the vast majority of patients they see are not there for emergencies. They are there because they are uninsured and this is the only way they can get to see a doctor. The financial burden of uncompensated care is leading to friction at the bargaining table, as public hospital administrators seek layoffs, wage cuts, and the substitution of lower skilled workers for more highly skilled ones. Our members would much rather be discussing ways to improve the quality of care that their patients receive.

The Need for an Employer Mandate

If we can agree that universal coverage is a necessity, the question becomes how to provide it. The strength of the employer mandate approach is that it builds on the existing system. Nearly two-thirds of the non-elderly have employment-based coverage. Among the 39 million Americans who lack insurance, 85 percent belong to families that include an

employed adult. A system that required all employers to contribute to the cost of health insurance for their workers would reach the vast majority of the uninsured.

An employer mandate that leads to universal coverage will also reduce costs for the majority of employers who are already providing health insurance. Right now, every bill we pay and every premium payment we make contains a hidden surcharge that goes to cover the more than \$25 billion a year in care that hospitals provide to the uninsured.

There is also a long tradition in this country of using employer mandates to provide workers with certain types of social benefits. These include Social Security, Medicare, Unemployment Insurance, and Family and Medical Leave just to name a few.

Many employers who are currently providing insurance are paying more than their fair share because they are providing coverage the working spouses of their employees. In essence, they are subsidizing their competition. A 1991 National Association of Manufacturers study found that the cost of providing coverage to working dependents increases costs for firms providing insurance by 20 percent.

The growing disparity in labor costs between firms that do provide health insurance and those that don't is generating serious distortions in the labor market. The dramatic increase in the number of part-time and contingent employees, which constitute half of all new jobs created during the past year, is being driven in large part by the desire of employers to avoid the cost of health care. Last year, SEIU building service locals in Los Angeles, Seattle, and Washington DC all reported that the cleaning firms they negotiate with were refusing to extend health care coverage to part time employees while they continued to expand their use of such workers.

A number of our employers are finding it harder to compete with firms that do not provide health insurance. SEIU Local 750, which represents building service workers in Orlando, Florida reports that one of its contractors lost a contract with Delta Airlines that it had held for over eight years to a non-union contractor. The non-union contractor did not provide health insurance for its workers, and thus was able to underbid the unionized contractor.

The loss of the contract added insult to injury, because the members of Local 750 have worked hard to keep costs under control. For over a decade, workers have been offered a choice of 3 HMOs and 1 PPO. In order to keep costs down, however, they have been forced to change vendors every two years. These changes often result in a disruption of established relationships with physicians and other providers.

In the public sector, proponents of privatization have argued that public services can be delivered more cheaply by private sector contractors. In most cases, however, we have found that the only reason that these contractors are able to provide the same services at lower cost is that they do not provide health insurance for their workers.

The experience of displaced workers demonstrates that high employer costs for health benefits are contributing to the destruction of jobs with health insurance on a massive scale. According to the Bureau of Labor Statistics, of 4.2 million workers had been displaced from jobs with insurance during the previous five years, only 2.2 million had been re-employed with health insurance as of January 1992. The rest were working without insurance, were unemployed or had left the labor force. While many these had coverage, the source was no longer their own employer.

The system of employer-provided health insurance is unraveling. In the absence of an employer mandate, firms will continue to limit the scope of their coverage or eliminate it entirely in response to competitive pressure. An employer mandate would level the playing field and encourage firms to take the "high road" to competitiveness by improving productivity and investing in their workers rather than the "low road" of wage and benefit cutbacks.

Some critics of the Health Security Act have argued that an individual mandate would be fairer and more efficient than an employer mandate. We would have to disagree. For one, an individual mandate would be tantamount to a substantial tax increase for the middle class. Second, it is likely that many employers, especially employers of low-wage workers, will drop their coverage entirely in response to an individual mandate. According to the Employee Benefits Research Institute, the number of non-elderly Americans receiving health insurance through their employer fell by 2.2 million between 1988 and 1992. The pressure on firms to drop insurance will only increase in the future as more and more firms seek a competitive advantage by eliminating these important benefits.

It is important to realize that none of the individual mandate proposals on the table contains any form of serious cost control. Over the last decade families have faced rapidly rising premiums and increased levels of cost-sharing. To impose a health insurance mandate on middle-class families without any assurances that costs will not continue to spiral out of control is simply unfair.

Even some who support the idea of an employer mandate believe that employers should only be required to provide a minimal, catastrophic benefit package or to only contribute 50 percent or less of the premium. SEIU takes issue with both these positions.

With respect to the benefit package, everything we've learned about the health care system over the past decade suggests that providing people with only catastrophic benefits leads to underutilization of primary care. This leads to higher costs in the long run. Denying coverage for prescription drugs drives up costs in the same way because it encourages patients to favor more invasive (and expensive) treatments simply because they are covered. Do we really think that denying people coverage for substance abuse treatment saves the health care system money? Once you start to think about it and work it through, you are led to the inevitable conclusion that a comprehensive benefits package is the only kind that makes sense.

SEIU is also critical of the idea that employers should pay less than 80 percent of the premium. When we talk about employers paying less, what we're really talking about is making workers pay more. Some of our members are already paying 30 percent, and even 40 percent of their premiums and it's killing them. If you assume an average family premium of around \$5,000, you're talking about hitting some middle-income families with a bill of \$2,500.

Health Alliances Will Only Work With An Employer Mandate

A central feature of the Health Security Act are the Health Alliances which would offer group purchasing power to employers. Some of the competing bills would make the Health Alliances voluntary and would lower the opt-out threshold so that the Alliances would only cover the smallest employers.

This would essentially kill the Health Alliances as meaningful entities. The lack of an employer mandate will almost certain to lead to adverse selection among workers in the Alliance. Those employees who are more likely to be sick will purchase coverage, while those are relatively healthy may go without coverage. This, in turn, will raise costs for those who do choose to purchase coverage. The result could be a vicious cycle that could well destroy the Health Alliance as a meaningful entity. If small employers are unable to realize lower premiums as a result of their membership, then they would be no more likely to purchase coverage for their workers than they are now.

With the help of the Robert Wood Johnson foundation, a number of states have experimented with purchasing cooperatives for small business that also operate on a voluntary basis. While some small employers did obtain coverage through these arrangements, even in the most successful project only enrolled 17 percent of employers who previously had not offered insurance. The Arizona Health Care Group, one of the longest running projects, only succeeded in enrolling 939 small firms, for a total of 3,093 covered lives, during the first three and half years of its existence. Similar experiments in other states proved similarly disappointing.

The results of the American Hospital Association's 1991 survey of chief executives of voluntary purchasing cooperatives were also discouraging. Less than half of those surveyed agreed that the cooperative had made a difference in controlling health care costs in their community.

Benefits for Employers Under the Health Security Act

Some employer associations have complained bitterly about the cost of an employer mandate, while ignoring the significant benefits that many businesses will receive as a result of the President's plan. Aside from cost control measures which will benefit both employers

and workers, the plan calls for a cap on employer premium contributions of 7.9 percent of payroll. Many businesses who provide health insurance to their employees currently pay more and stand to gain a windfall under the plan.

The President's proposal also calls for a lifting of the heavy burden on businesses competing in the global marketplace by subsidizing the crippling costs of early retiree health care coverage. Most of our major international competitors spread the cost of retiree coverage across their entire population. We must follow the same path if our products are to be competitively priced and our domestic productivity is to be enhanced.

Some members of Congress are suggesting that the Clinton plan is financing reform on the backs of small businesses. The truth is that the majority of small businesses already provide health care coverage to their workers and are among the biggest winners under the Clinton plan. The Health Security Act takes three strong steps to address the cost burdens of small businesses.

First, the Health Security Act gives small businesses the power of numbers. If we pool small businesses and the self-employed together and allow them to buy private coverage through purchasing groups, they'll have the market power big businesses have to get better prices and guarantee employees a choice of good plans. Second, insurers will have to charge a small business employee the same price as their other customers. Finally, under the Health Security Act, small businesses would have their premium contributions capped according to their ability to pay. The smallest businesses employing predominantly low-wage workers would pay no more than 3.5 percent of payroll.

Truth and Fiction About Job Loss

No issue has been more deliberately distorted by opponents of the Health Security Act than the plan's impact on jobs. Two commonly cited studies, by the Employment Policies Institute and the CONSAD Research Corporation, make several fundamental errors in characterizing the Health Security Act. They completely exclude from their analysis the discounts to small and low-wage businesses that the plan provides; they use a benefit package that is far more expensive than that included in the Act; and their assumptions about how firms change their employment in response to cost changes is at least three to six times higher than most conventional estimates.

Real world evidence suggests that mandates do not have a major impact on the number of jobs available. Hawaii imposed an employer health insurance mandate in 1974. Since then, private non-farm employment in Hawaii increased by 90 percent, compared to 54 percent in the United States as a whole. Employment in retail and wholesale trade, which in theory would have been especially vulnerable to the mandate because of the large number of minimum wage workers, actually grew faster in Hawaii than in the United States as a whole.

The effect of any mandatory health insurance contribution will be greatest among workers who are paid the minimum wage. This is because the statutory wage minimum precludes any offsetting wage reductions in response to the mandate. Hence, most observers agree that, with respect to low-wage workers, mandatory employer health insurance is tantamount to an increase in the minimum wage.

Fortunately, there have been a number of recent studies about the impact of increasing the minimum wage. Professor David Card of Princeton University examined what happened when California increased its minimum wage in July 1988 by 27 percent. At the time, 11 percent of the state's workers earned less than the new minimum of \$4.25, including 50 percent of teenagers. Professor Card compared California's employment experience with states where no increase occurred. The analysis showed that while the earnings of low-wage workers did increase, there was no employment effect, even among teenagers. Furthermore, Professor Card found no relative shrinkage of employment in retail trade, the sector most dependent on minimum-wage labor.¹

In another study, Professor Card compared the experiences of low and high wage states which have different proportions of workers affected by changes in the federal minimum. Again, no negative impact on teenage employment could be discerned.²

Lawrence Katz of Harvard University and Alan Krueger of Princeton University collaborated on a study of fast-food outlets in Texas. They, too, found no negative employment effects as the federal minimum wage rose by 27 percent between 1990 and 1991.³

As the graph makes clear, for the smallest firms employing minimum wage workers, the cost imposed by the Health Security Act will be no more than 15 cents per hour, significantly lower than the 90 cent per hour increase in the minimum wage signed into law by President Bush in 1989. For larger firms with such workers, the cost would be no more than 35 cents per hour.

Given the overwhelming evidence that an employer mandate will have a minimal impact on employment, one can only conclude that the mandate's opponents must be motivated by partisanship and ideology. Their arguments have no basis in fact.

¹David Card, "Do Minimum Wages Reduce Employment? A Case Study of California, 1987-89," Industrial and Labor relations Review, October 1992, v.46, n.1, pp.38-54.)

²David Card, "Using Regional Variations in Wages to Measure the Effects of the Federal Minimum Wage," Industrial and Labor relations Review, October 1992, v.46, n.1, pp.22-37.)

³Larry Katz and Alan Krueger, "The Effect of the Minimum Wage on the Fast-Food Industry," Industrial and Labor relations Review, October 1992, v.46, n.1, pp.6-21.)

It is also untrue that the Health Security Act will eliminate part-time jobs. It's true that employers would no longer have an incentive to hire part-time, temporary, or contract workers simply to avoid paying for health care coverage. But the plan isn't biased against part-time work either since premiums are pro-rated for part-time workers.

While some previously uninsured workers may see smaller wage increases as the mandate is phased in, all workers will benefit from controlled health care costs.

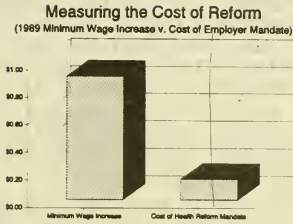
In a study SEIU published with Lewin-VHI, we reported that the failure to control healthcare costs since 1980 meant that the average worker took the equivalent of a five percent cut in take-home pay in 1992.

Few studies of the Health Security Act have attempted to quantify the job gains from businesses whose costs will fall under health care reform. A recent study from the Economic Policy Institute found that firms in the manufacturing sector will save \$18 billion compared to their expenditures under the current system. These savings will increase manufacturing-related employment by 112,800 jobs during the first five years after the plan is implemented.

Nor has much attention been paid to the potential for job losses if we continue on our present course. A 1992 study by the University of North Carolina School of Public Health found that our failure to control health care costs over the last decade resulted in one million fewer jobs being created. The study also found that rising health care costs will lead to the elimination of 1.5 million jobs over the next five years.

To conclude, let me say that the Health Security Act, and the President's political commitment to health care reform, offers the best hope for achieving our long sought goal of universal health coverage. We intend to defend the Health Security Act against those who will advocate that we move more slowly, make incremental changes, or simply endure our current situation. We are committed to spearheading a coalition of consumers, senior citizens, businesses (large and small), community groups, and progressive providers to fight against those special interest groups defending their financial stake in the status quo.

Once again, I want to thank the Chairman and the other members of the subcommittee for this opportunity to testify. We look forward to working with you to make the vision of "Health Care That's Always There" a reality for America's working families.



Mr. GIBBONS. Mr. Dunton.

STATEMENT OF JACK SHEINKMAN, PRESIDENT, AMALGAMATED CLOTHING AND TEXTILE WORKERS UNION, AFL-CIO, AS PRESENTED BY BRUCE DUNTON, VICE PRESIDENT, MID-ATLANTIC REGIONAL JOINT BOARD, AMALGAMATED CLOTHING AND TEXTILE WORKERS UNION, AFL-CIO

Mr. DUNTON. Mr. Chairman, my name is Bruce Dunton. I am vice president of the Amalgamated Clothing and Textile Workers Union. I serve on every major Taft Hartley Fund in our union, and I am the chairman of one.

In the past 10 years, we have spent more time in the funds trying to put before our members 800 numbers to call and ways in which to ratchet down the costs without providing any additional benefit to them. We are in favor of the universal health care and the universal employer mandate.

I am also privileged to represent some of the lowest paid people in this country. In the apparel end of our union, it is 95 percent made up of females. They make the suit that I have on. They make the shirt I have on. They make the necktie that I have on. They made the coat I wore in here. Their average wage is \$7.50 an hour.

We have two major funds which we are proud to say in 1994 that we do not have copayments for these low-paid people, but it is a major struggle for the employers that are in those sectors of our union. We do not have huge deductibles. They cannot afford it. They cannot afford the \$200 deductible they have now. And we sit across the table from employers that do have high deductibles for themselves and pay a copayment, and to them I say, with their \$100,000 salaries, they can afford it. Our members that are making \$10,000 to \$15,000 a year cannot.

A third of these members are single head of household. The husband, the mate left them. No money coming. They ask nothing from our government, except to have a job. They are primarily in rural communities and with NAFTA staring us in the face, our competition gets keener and keener.

We represent companies on both sides of the border. There is a minimum of a 6 percent advantage on health care to our Canadian firms. Our members in Canada do not hear what I have said, do not say to us what I have heard here this morning, that they are unhappy with their coverage. I have noticed over the last 10 years in this community that there have been a number of times that this government has stopped paying the employees because they have not had the funding in place. I assume a similar thing happened in Canada.

We have in my district that I represent Masland Carpet. They operate in Lewistown and Carlisle, Pa. They operate in Ontario. There is a 6 percent advantage on health care. Our members are no better off in Pennsylvania than they are in Canada.

We represent Owens-Corning Fiberglas and Mount Union in Huntington, Pa. We represent them in Cornwall, Ontario, also. They are no better off, and there is a 6 percent advantage there.

We have companies in the United States that have a distinct disadvantage, both with Canada and other countries we compete with. All of the industrialized world has universal coverage.

In the past 3 years, I have noticed at the bargaining table, and this is new to me, that I am sitting in single contract negotiations where this takes most of the time, and we have people that now have no coverage because they cannot afford in some cases \$50 a week as a copayment or \$500 to \$2,000 deductibles. They get no coverage. And they are at the mercy of figuring out which hospital can put them into the emergency system when they need treatment. But no longer are we talking about preventive care, we talk about we are dying, and we have to find the emergency ward that will treat us. They know where to go, but we are all paying for that.

So in conclusion, Mr. Chairman, and the committee, we favor an aggressive payment system so that the low paid that are struggling to make ends meet and rapidly falling backward in their standard of living can have universal coverage, do not have to worry about whether or not they can go see their doctor for treatment and stop blaming the whole medical society for all of the problem.

One final thing. Our health plans, when we see the prices of administration getting beyond the 6 percent range, we start asking the administrator if he likes his job. So I don't understand how we can worry about billions and billions of dollars if we are going to have a card and cut out a lot of the paperwork in this country and get on with it.

Thank you for the opportunity of being here.

Mr. GIBBONS. Thank you, very much, sir, and I thank all the panel.

[The prepared statement follows:]

**STATEMENT OF JACK SHEINKMAN
PRESIDENT
AMALGAMATED CLOTHING AND TEXTILE WORKERS UNION**

ACTWU members, like millions of working Americans who now have insurance, are suffering the consequences of a health care system in which some employers get away with providing little or no insurance for their employees and dependents. This system puts socially responsible companies at an unfair and serious competitive disadvantage. And that means lost wages and lost jobs for insured workers. ACTWU firms with insurance are also paying more than companies in other countries with less expensive universal health care systems.

As low wage workers in the textile and apparel industry who are representative of low wage workers in general, ACTWU members are also concerned that universal health care be progressively financed, like their own union plan, using a percentage of payroll formula. The overall current health care financing structure is highly regressive for companies and workers. Health care reform needs to reverse that pattern so that universal coverage does not create new competitive problems for companies or severe hardship for workers.

A universal health care system that uses an employer mandate with equitable financing would eliminate the unfair competitive advantage held by those firms who deny health insurance to their workers. Such a system would also bolster U.S. competitiveness with those countries that have affordable universal coverage. HR 1200, the American Health Security Act, would create simple, equitable financing for universal health care, and has the best proposal for overall reform. The Clinton proposal would move health care towards fairer financing, but uses mechanisms that are more complicated than they need to be.

Lack of Employer Mandate Distorts Competitiveness

Through our experience in collective bargaining and organizing, the Amalgamated Clothing and Textile Workers Union is confronted daily with the competitive distortions that result from some companies providing health insurance for their workers while others do not. Non-union firms often provide partial or no coverage or require co-payments on coverage for dependents that is prohibitively expensive. For example, before they unionized, single mothers making curtains for K-Mart at the S. Lichtenberg Company in Georgia were taking home \$150 a week. The company charged them \$68 a month if they wanted to cover their children under an insurance policy with a \$500 deductible. After paying for food and shelter, almost none of the 530 workers were able to but family coverage. In their first union contract, the company and workers joined the national ACTWU health plan with an affordable "community" rate, no premium payments by workers and a \$200 deductible. Hundreds of children became protected by health insurance for the first time. Now the company has to find other ways to compete with curtain firms that have the non-insuring edge.

There are many ways that insuring firms are hurt by those who don't insure their workers. First, the non-insuring firms have lower operating costs and can underbid firms with insurance. Second, the insuring firms end up covering the spouses and dependents who work for non-insuring firms. This includes wives who work in retail stores and husbands or college students who work for small businesses. (About 65% of retail employees and 31% of firms

with 10 or fewer workers had no company insurance in 1992.¹) Third, cost shifting by health care providers means that insuring firms actually pay the bills of employees of non-insuring firms. (About 30% of private insurance hospital bill payments cover nonreimbursed expenses of other patients.²) Finally, to the extent that the government pays the bills of the uninsured, all taxpayers, including insuring companies, pick up the tab for non-insuring firms.

Health care reform should remove the competitive edge currently enjoyed by those firms that foist their workers' health care bills onto other companies and taxpayers. Given the countervailing profit incentives, nothing short of a universal employer mandate can guarantee that all employers make a fair contribution to coverage and that all workers and their dependents are insured. An employer mandate will provide coverage for 85% of the currently uninsured-the employees (and their dependents) of non-insuring firms. This follows in the footsteps of mandatory Social Security contributions by all employers.

We negotiate health plans with hundreds of small businesses. So we feel obligated to counter the hysteria that is being whipped up against the employer mandate by some small business organizations. These are the same groups that said increasing the minimum wage would close businesses and kill jobs. But the actual minimum wage increases in 1990 caused no job loss.³ Now they're saying that mandatory premiums, no matter how small, will close businesses and kill jobs. They're wrong this time, too. Small business can afford insurance if it's equitably financed.

Equitable Financing is Key to Equitable Employer Mandate

While we feel very strongly that all firms should provide insurance for all their employees, we know that charging the same flat premium to every company could create new competitive problems. If the premium is too high, an employer mandate could threaten the viability of some labor-intensive, low-profit-margin firms from apparel companies to retail stores.

A high, flat premium would also continue to put U.S. firms at a competitive disadvantage internationally. For example, in 1992 Levi Strauss paid premiums equal to 19% of its Florence, Kentucky plant payroll but paid an amount equal to only 4% of its Stoney Creek, Ontario (Canada) payroll for similarly comprehensive health insurance. This creates an incentive for relocating production to non-U.S. plants. A similar cost gap exists between the largest U.S. men's suit manufacturer, Hartmarx, and its Canadian competitor, Peerless, which is exporting almost 300,000 suits to the U.S. annually. Canada's pre-eminence as the largest exporter of men's wool suits to the U.S. is helped in part by Canada's less expensive national health insurance.

¹ Employee Benefit Research Institute, EBRI Issue Brief (EBRI tabulations of 1993 Current Population Survey), January 1994.

² Economic Policy Institute, "The Impact of the Clinton Health Care Plan on Jobs, Investment, Wages, Productivity, and Exports", 1993.

³ Ibid.

Charging the same high flat premium to all workers threatens the already tenuous living standards of low-wage workers. Currently workers can't afford to buy insurance once they've paid for food and shelter. How will they feed and house their families if the premiums become mandatory and their incomes remain the same? The costs of insurance must be distributed fairly based on companies' and individuals' ability to pay. The high price and unfair distribution of health care costs in the current system is the engine that drives firms and individuals to drop coverage.

Current Health Care Financing Is Regressive

The current financing of health care is extremely regressive. A recent study found that low-income families pay over twice the share of income for all health care expenses as high-income families.⁴ As a share of income, low-income families spend four times as much as high income families for premiums, even though many poor families are uninsured and don't pay any premiums. Out-of-pocket spending is even more regressive, with low-income families spending nine times what high-income families spend even though poor people can't afford to spend much at all on uncovered bills and deductibles.

The only portion of health care financing that is equitable is the portion covering programs that are paid for through personal and corporate income taxes at the Federal and state level. But other taxes, such as sales taxes, hit low-income families harder. Although they are covered by Medicare, the elderly pay more of their own money for health care than people under 65, and low-income elderly pay even more, proportionally, than other low-income families.

The Fairest Financing Method Is Also the Simplest

The majority of health care is funded through premiums and out-of-pocket spending--the two most regressive forms of financing. Fortunately, the most equitable method for financing health care, a payroll premium by firms and workers, is also the simplest to administer.

Traditional insurance premiums are flat dollar amounts that by their nature are a greater burden for low-income people. This burden is made even heavier by having different rates based on family size--the more mouths you have to feed, the higher your insurance premium. Under the current system, contingent workers--part-timers, temporaries and independent contractors--pay higher individual premiums than employees in group plans even though they often have lower incomes. Finally, smaller firms pay higher rates than larger ones.

HR 1200 provides the most equitable and simplest solution to financing health care: transforming per capita premiums into a progressive payroll premium structured like Social Security. The combination of a 8.4% payroll premium for companies (4% for small/low wage firms) plus a 2.1% payroll premium for workers would cover the costs now covered by regressive flat premiums and out-of-pocket payments.

⁴ Edith Rasell, Jared Bernstein, and Kainan Tang, "The Impact of Health Care Financing on Family Budgets," Economic Policy Institute, 1993.

These 8.4% and 4% payroll premiums are fair to a wide range of companies and workers. It represents significant savings for most companies that now insure their workers and a reasonable cost for those that do not. It is in line with amounts paid by our competitors in the developed nations. It automatically covers most contingent workers. This mechanism provides the core financing for HR 1200, which we believe is the best bill overall for solving the health care crisis.

The Clinton plan creates a hybrid premium in the form of a flat rate with a payroll payment maximum of 7.9% for companies and 3.9% for individuals. These caps, along with the subsidies for small businesses and the very poor, make premium financing less regressive than the current system. But it creates a system that is much more cumbersome than a progressive payroll premium. This hybrid premium would require several billion dollars each year in unnecessary administrative costs to determine employment status, family structure, employment status of dependents, and which firms and individuals are eligible for how much of a subsidy. While simplicity is supposed to be one principle of the Clinton plan, its financing is much more complex than it needs to be.

Cost Sharing Is Not Justified

The other highly regressive component of health care financing is out-of-pocket expenses, including deductibles, co-payments for premiums, uninsured portion of bills, and uncovered services (often drugs and mental health care). People with low incomes can't afford to buy the health care they need. Yet they pay almost a nine-times larger portion of their income out-of-pocket than high-income families for the health care they get. Furthermore, a single catastrophic illness can propel even middle-income families into bankruptcy due to uncovered bills.

Increasing out-of-pocket burdens have been advanced as a cost containment measure and a means to reduce unnecessary use of medical services. But, it is not clear that America overuses health care compared to our international competitors. Americans go to the doctor less and stay in hospitals a shorter period of time than consumers in every other major industrialized country. These nations get more services for less money despite universal coverage and little or no cost-sharing.

What is clear is that co-payments and deductibles discourage 24% of people with insurance from seeking the care they feel they need.⁵ What is also clear is that low-income people in America have worse health when they are subjected to cost-sharing. Americans who can't afford to go to a doctor put it off till they land in a hospital emergency room where more expensive heroic measures have a much lower chance of actually providing a cure.

HR 1200 uses payroll premiums plus some sales taxes to fully fund health care without any deductibles or co-payments for insurance or for medical services. This is similar to systems among our international competitors. Cost containment and the problem of inappropriate care are addressed without

⁵ Mark D. Smith, Drew E. Altman, Robert Leitman, Thomas W. Moloney, and Humphrey Taylor, "Taking the Public's Pulse on Health System Reform", Health Affairs, Summer 1992, p. 130.

creating financial barriers to necessary services. We feel this bill incorporates the best way to finance health care and the most effective cost containment mechanism.

The Clinton plan reduces out-of-pocket costs for the uninsured and some of those with insurance. But it increases the out-of-pocket burden for many workers who are currently covered by employer or union health plans. We see several problems in the Clinton plan's approach to out-of-pocket costs.

Many union and non-union workers do not currently pay a portion of premium costs. Our union has seen too many families in unorganized plants "choose" not to have coverage simply because they couldn't afford it. As a result, we have insisted that our largest national tailored clothing and cotton shirt and jeans contracts have fully-employer-paid insurance. We feel very strongly that the Clinton plan should have a cap on employee contributions that is closer to 2% than 3.9%. If the new system uses subsidies, they should also help the lowest-income families pay for premium co-payments.

We are concerned about how large a gap there will be between HMO, PPO and fee-for-service premiums under the Clinton proposal. We fear the creation of a Medicaid-type second tier system of HMOs with low quality care and no middle-class constituency. This will occur if significant differences in premiums and out-of-pocket expenses take fee-for-service insurance out of the reach of all low-income families. We are also very concerned that companies pay a fair share of the premium for all contingent workers. There should also be subsidies for the "employer" share of premiums paid by low income contingent and unemployed workers.

The Clinton plan includes a \$3,000 annual out-of-pocket limit for families. This constitutes 10% of annual income for a family earning \$30,000, but only 3% of income for a family earning \$100,000. This flat amount should be replaced with a low, medium and high stop loss based on income. This would be revenue neutral, but could remove a serious barrier to medical care for low-income families.

The additional, \$250 prescription drug deductible is essentially an excise tax on drugs that will be paid primarily by people with chronic conditions. A huge body of evidence shows that such deductibles discourage many low and moderate income people with conditions like hypertension from taking medications that can prevent heart attacks. This deductible is penny wise and pound foolish given the relative expense of the medicine vs. heart surgery.

Once again, it is important to note that many of these subsidies and sliding scales would not be necessary if health care were financed through an across-the-board progressive payroll premium. We do, however, feel it is important to point out necessary adjustments that need to be made within the Clinton framework if health care is to have equitable financing.

Any New Taxes Should Be Fair

Payroll premiums fall only on wages and salaries and does not impact non-labor income such as dividends, interest and rents. Equitable financing of health care therefore should include some payments based on total income or

non-labor income. Excise taxes, such as the proposed cigarette tax, are the most regressive taxes of all. A cigarette tax would take a 72 times greater share of family income from the lowest 20% of families compared to the top 1% of families. While a cigarette tax has some justification as a health measure, it must be counter-balanced with less regressive financing provisions.

Conclusion

A universal health care system that uses an employer mandate with equitable financing would eliminate the unfair competitive advantage now held by non-insuring firms. It would also bolster U.S. competitiveness internationally. HR 1200 provides simple, equitable financing for universal health care and the best proposal for overall reform. The Clinton plan would move health care towards fairer financing, but uses mechanisms that are more complicated than they need to be.

Mr. GIBBONS. Let me go down the batting order today and, say that I have a sheet here prepared by our clerk on the Democratic side as Gibbons, Stark, Coyne, Cardin, McDermott, Kleczka, and Kopetski. On the Republican side it is Archer, Thomas, Johnson, Bunning, and Hancock. And the rest of you are relegated somewhere way below that. You may want to get lunch before we get to you.

I am going to waive most of my time since I have taken up a lot of time, except to say to Mr. Dunton, I am glad you gave us that comparison. I am sure there are some faults with the Canadian system, but, you know, the Canadian people love it, as far as I can tell. I have been to Canada a number of times and talked to a lot of Canadian people and they think they are better off than we are and they kind of look down their nose at us. They think they have a better health care system than we do. They are pretty nice and pretty well-educated people, and I think they are probably right.

I also know a number of Canadian doctors, and most of the Canadian doctors I know like the system. So it is possible to have a system other than what we have in an economy and a society that is very similar to ours. Our next door neighbors have it.

That is all I have to say. Mr. Stark, you are next.

Mr. STARK. Thank you, Mr. Chairman, and I appreciate the testimony of the witnesses. While I am sympathetic, for example, to Mr. Brennan's concern for his low-income employees, I get a kick out of his numbers. He says his average employee contributes \$1,740 to corporate earnings. So I presume that if you are making around \$500,000, Mr. Brennan, if you quit, your earnings would go up in the company by \$498,260.

I don't think those numbers are relevant. I do think it is relevant to discuss the fair share of what employers should pay, but I guess as the major representative of employers, we have the group that is most concerned about social values and the quality of life for Americans—the U.S. Chamber.

Mr. Patricelli, I have a little problem with your duplicate testimony here. Did you ever read the Rubaiyat?

Mr. PATRICELLI. I have read parts of it.

Mr. STARK. "The moving finger writes; and having writ, moves on. Nor all thy piety nor wit shall lure it back to cancel half a line, nor all your tears wash out a word of it."

Now, your initial testimony, which people were running around here trying to pick up—I could sell at a high price. It is getting scarce. It goes to the rare book section. You said that you accept the proposition that employers should provide and help pay insurance on a phased-in basis. That was as of last night. Now, I gather as of this morning, you said we cannot support the President's Health Security Act because of the high burden of an employer premium contribution and that you cannot support any of the mandate proposals that have been put forth.

So you quarreled in your initial testimony with the size, which I think the President has suggested is negotiable, and you think 80 percent is too high. I just wonder if we could determine where you as the voice for all of the major unindicted large corporations in the United States stand at this point.

Do you think that it is fair for businesses who pay toward providing benefits for their workers, is it fair for those businesses to have to subsidize your members who pay nothing?

Mr. PATRICELLI. Well, first of all, Mr. Stark—

Mr. STARK. Is that fair?

Mr. PATRICELLI. First of all, Mr. Stark, I prefer Casey Stengel to the Rubaiyat, and in this case, it ain't over 'til the fat lady sings, and I am the fat lady when it comes to the Chamber policy.

Now, the Chamber has not changed its policy. There were certain elements of detail that staff took a crack on that senior members of the Chamber had not reviewed and went beyond what the board policy was.

Mr. STARK. Let's get down to it. Do you support every employer having to pay something, if that is the law of the land to achieve universal coverage?

Mr. PATRICELLI. Mr. Stark, I am not going to answer absolute questions. We support the concept of shared responsibility but in the context of a proposal that works. Just like we support—

Mr. STARK. I will stipulate to that. Proposals have to work, and I am perhaps of one of the leading critics of H.R. 3600, but we are not going to write a bill and see it passed, to pass the test of fairness in the United States, if you give a subsidy to some businesses who do not pay their fair share.

If you accept the fact that employers have some responsibility to pay benefits for their employees, and I believe that has been established since World War II, then the question is how much and through what procedure do employers pay? Will you accept the factor, the hypothesis, that every employer should, in the spirit of getting universal coverage, pay something?

Mr. PATRICELLI. In fact, the board-approved policy suggests that that is the proper way to go. Now, what we have seen happen since the board in February 1993 approved that statement was the elaboration, through bills and proposals and particularly the Health Security Act, of such a weight of cost and regulatory burden—

Mr. STARK. I would throw up before I would vote for the Cooper bill, for example, so I understand your problem. There is a lot of bad legislation out there. But before we can write a bill that we can get a compromise on, we have to, first of all, pay for it.

Let's go back to 1990 and 1991. I presume the U.S. Chamber opposed both of the 45 cent minimum wage increases; right?

Mr. PATRICELLI. I don't know, I would have to ask.

Mr. STARK. But I would also submit to you that the 90 cents in those 2 years really did not break anybody because everybody was required to pay—many businesses were already paying more—but I don't think you can point to any businesses that went bankrupt just because of that factor. Is that a fair guess?

Mr. PATRICELLI. You can draw your conclusion on that.

Mr. STARK. You would not want to argue with that much, would you?

Mr. PATRICELLI. Well, Mr. Stark, I think you want to know whether there are any circumstances under which the Chamber could support a mandate?

Mr. STARK. Well, I want an amount. Because you might like an amount, I think is what you are telling me, but you don't like the plan. So you wouldn't pay 10 cents for the current plans. That is fair.

I am saying if we can find a plan, then we have to pay for it. There are two steps. I think the President may be too high on big business. At 3½ percent on a minimum wage employer, he is talking 15 cents an hour. I mean that is peanuts.

I am just trying to suggest to you that we are not going to destroy your membership if we keep in the boundaries of the old minimum wage increases. If we look at that and say, yes, nobody liked it, we understand that—nobody ever likes the taxes that we write—but if we are in that range and there is a plan that people like in general, that we can get a majority of businesses to support, do you think that that would cause irreparable harm to your membership if we are in that range, as a minimum contribution?

We have to have some guidelines here from you.

Mr. PATRICELLI. Well, I am afraid that we do not have board policy on the precise amount of an employer payment requirement that might be acceptable. We have not rejected mandates out of hand.

Mr. STARK. OK.

Mr. PATRICELLI. We have not found one yet that seems to work in a balanced program. And to repeat a point that is very important, and I say this sincerely, we are concerned, as many businesses are, that if and when you start down that track, the natural effect of the political process may be to add such costs to it, if not in year 1, in years 2 and 3, that we then find we have started down a track we cannot sustain.

Mr. STARK. If the Chair will indulge me for just 1 second.

We will stipulate to that. The costs of government and the costs of living in this country have escalated over the last decades and the cost of taxes and the cost of the deficit. We know that. Nobody is trying to kid you. But we still have the number of uninsured going up and the cost of medical care going up disproportionately.

If we could find a plan that will find acceptance in the labor community, the business community, we are still stuck with a way of paying for it. And you and I know that taxes are the worst thing this committee has to do. We need some sense that if it is under \$1 an hour, not percentages, somewhere that businesses will say, OK, if it is a good plan and if it is fair and if it does not adversely impact on certain businesses to the disadvantage of others, would you chip in? That is my final question.

Mr. PATRICELLI. We would be open to see such a plan. We do not reject mandates as a theoretical manner.

Mr. STARK. Thank you.

Mr. GIBBONS. OK, let's go. I hate to be arbitrary, but I am going to—there are so many of us, I will have to watch the lights very closely.

Mr. Archer.

Mr. ARCHER. Thank you, Mr. Chairman.

We have heard a good bit today about what we can learn from other countries. My colleague, Mr. Bunning, made the observation that this country is different in the world and most people want to

emulate us and are moving in our direction. But it is fascinating to note that the country that President Clinton said we could learn the most about in health care is Germany, and in Germany, over the last 3 years, health care costs have gone up at an aggregate rate of 23 percent, more than the general rate of inflation in that country.

In the United States, good things are already happening that nobody seems to want to pay much attention to, because last year the health care costs went up only about 2½ percent above the rate of inflation. If we want to model our program after Germany, we are looking at much, much bigger increases in health care costs. We need to pay attention to the things that are already happening that are beneficial in this country.

Now, there has been a lot of debate as to whether this mandated employer premium is a tax and whether it ought to be on-budget or off-budget and different people have different views. But I assume that each of you witnesses attempted to read the language of the administration's bill, and I assume that most of my colleagues have. But let me read you one quote that relates to the employer-mandated premium, and now I quote from the Clinton bill.

"The amount under this subsection for an employer is equal to the premium payment amount that would be computed under section 6121(b)(2) if the per capita collection shortfall amount, (computed under section 6107(b)(1)), for the year were substituted for the reduced weighted average accepted bid for the year. The reduced weighted average accepted bid is used under section 6122(a)(1) in computing the base employment monthly premium which in turn is used under section 6121(b)(2)(a) in computing the employer premium amount."

Now, come on. We all know that that technical language is suitable only for tax lawyers. How can they not call this a tax? And it may explain why there are more lawyers in this room today than there are health care experts. Those kind of complexities that are going to be laid on small businesses in this country are even beyond the question that you mentioned in your testimonies.

Under most of the proposals, other than the House Republican Leadership proposal, H.R. 3080, everything is third-party payer, where the individual has no stake in trying to get value for medical care. In our proposal, we have the Medisave plan, which was sponsored by Congressman Jacobs and I in the House as freestanding legislation, and has been put in our proposal, which would let the employee have a trust amount to pay for their own bills, up to a certain limit, and then an umbrella policy for major medical over and above that, so that the employee became involved in seeking the best value of medical care. It is the only proposal which gets away from a third-party payer.

I would like to ask you people who are employers and those who represent employees how you would feel about such a potential alternative proposal. Not a mandated proposal but an alternative for you to use so that the employee who is prudent in seeking value for health care can then carry over any excess into an IRA under the name of that employee in future years.

Mr. Pinkus, would you like to start off?

Mr. PINKUS. I can comment on that. I think we look at any system that would not jeopardize job growth would be definitely better than an employer mandate. And the proposal, the Medisave proposal that you are talking about, really helps do that.

The biggest problem I think that we have with health care is the cost. And one of the reasons that we have such a big problem with cost is because the people who use health care are not concerned with cost. I think somebody once said that if employers paid for groceries, you would not be able to find hamburger in the grocery store because it would be ground steak. Until we get a system where the people who are using the system are concerned with costs and keeping the costs under control and actually bearing some of the costs themselves, we are not ever going to get the costs down and keep it under control.

And anything that will do that, such as your Medisave system, where people really know when they are paying the bill that it is their money that is paying the bill, that we will never get our costs under control.

Mr. ARCHER. Mr. Brennan.

Mr. BRENNAN. I don't think there is any question that when the employer and employee work together, understanding their needs and the best plan for them, you will control costs much better.

I don't understand the economics of your plan in total, but directionally, clearly, when you have the employer and employee working together, you will better control costs.

Mr. ARCHER. Anybody else?

Ms. CONNERTON. I would like to comment by saying that, first of all, there is nothing in that proposal that will guarantee universal access. You have still ignored the central question before us today, which is how do you pay for health care.

The second thing is that the Medisave policy, particularly for the kinds of workers that I represent, would be a big negative because, in fact, just like the 401(k) plans, these workers cannot afford to make significant contributions to IRA plans today.

Mr. ARCHER. Ms. Connerton, if you read this proposal, you will notice that it applies to all employees; that they would, if it were used as an option to insurance, if only it were used as an option to a standard core policy insurance, it would provide that they had to be given x number of dollars per year with a major medical umbrella policy over that.

So your employee that you represent would have the same advantage as any other employee to spend their own money up to the same amount in buying their medical care.

Ms. CONNERTON. Well, first of all, let me just say that the problem with that is that because it is a fixed contribution kind of approach, it does not at all deal with the question of what is happening to rapidly rising health care costs.

And, second, young healthy workers would have incentives who do not get sick or do not use medical care, would end up with higher amounts or rebates or IRA-directed savings than older workers who need health coverage. So it is a discriminatory policy, but, most importantly, it is a fixed contribution approach.

Mr. GIBBONS. That is all the time, I am sorry, we have.

Mr. ARCHER. Thank you, Mr. Chairman.

Mr. GIBBONS. Mr. Coyne, would you like to inquire?

Mr. COYNE. Pass, Mr. Chairman.

Mr. GIBBONS. Mr. Cardin. Mr. McDermott. OK. Mr. Thomas is here. We will go to him.

Mr. THOMAS. Thank you, Mr. Chairman.

One of the things I hope we do as we continue to carry out this health care debate is to not live in the late 1980s. I have heard several folks testify that we are in the middle of this constantly increasing health care cost.

The numbers that have been published and locked in on medical-price inflation clearly do not reflect the double digit increases of the mid and late 1980s. You folks act as though the private sector has not reacted. You know you have. As employers you have made adjustments. As representatives of employees you have made adjustments. And what has happened is those numbers have begun to come down.

In 1990, the medical-price inflation rate was 9.6. In 1991, the high 7s; 1992, 6.6; this year, 5.4 percent; and in the fourth quarter it was 4.4 percent. Do not tell me that the cost is totally driving the problem. It is something that we will deal with. Every major plan is going to deal with it.

Mr. Dunton, when you talked about the concern about administrative simplification, it is going to be in there. We need those tools of administrative simplification, one, to save money; but, two, to provide us with computerized information about procedures and practices; one, so that we can better work with the medical community but, two, to educate the consumer, which, in my opinion, is the key to keeping costs down in the long run.

We are all going to have antitrust reform. Frankly, the President does not go far enough, in my opinion, in malpractice reform, but we are going to have a major malpractice reform. Insurance reform is obvious. So when you look at the heart of the debate, we go back to the employer and the employee.

My friends on the other side of the aisle want the employer to pay for it. I think, in the long run, and Mrs. Connerton, your testimony I think clearly proved it, it is the employee who will wind up paying for it.

Now, you cannot have it both ways. If you argue that total compensation has had to go up to cover fringe benefits and, therefore, wages tend to go down; if in fact an individual mandate is imposed upon the employee, are you not going to sit down as the representative of the employee and indicate that you need to focus on the wages if the employer is not going to pick up a fair share of the cost?

Why is it government that is going to dictate that one side wins in this negotiation? I want to see the employee and the employer negotiate what that payment would be. But with an employer mandate, there is a requirement that the employer has to pay at a certain level. It seems to me that if the mandate is on the individual, then the collective bargaining process will determine whether or not it is the employee or the employer or a mix of the employee and the employer that will pay.

First of all, let us get serious. The reason the total compensation package has gone up is, one, yes, health care costs have gone up;

but it is a chicken and egg problem. The reason they have gone up is because the employee does not pay any attention to how much it costs to utilize the services. The only threshold question ever asked is does my insurance cover it? And one of the reasons is that government has allowed both the employer and the employee to shove the costs off on the taxpayer by virtue of a no tax cap in the Tax Code.

I think discipline starts with the understanding that you cannot have everything you want. So I think you have to have a tax cap. Now, in H.R. 3704 the tax cap is part of the beginning of the process. In the President's plan, it does not kick in until 10 years later. So when you look at the alternatives, it seems to me that the individual mandate will be resolved between the employer and employee where it should be, in the private sector.

And I would invite anybody's response to the package known as H.R. 3704, which was the last major bill introduced for a very good reason—we wanted to see where everybody else was going to be in terms of the structure. And the learning curve for all of us is far better now than it was earlier.

Has anybody looked at H.R. 3704, the Chafee-Thomas bill, which has an individual mandate, which has voluntary purchasing co-operatives, which has all of the changes that we have talked about, which makes a better package, and which has a tax cap, which is the only responsible way to begin to get costs under control? Any reaction from anyone?

Mr. DUNTON. Yes. Bruce Dunton. Unless we have universal coverage, we are fighting a losing battle.

Mr. THOMAS. We have universal coverage under H.R. 3704. There is a mandate by 2005. And the way we pay for the expansion of the coverage through vouchers and the income tax structure is to make savings in Medicare. Not unrealistic ones like the President's, but realistic ones. And when they are made, it is applied to a voucher to buy down the cost of insurance. So it is a universal mandate and everyone agrees.

Mr. DUNTON. As the deductibles in this country skyrocket, the low-paid people of the Nation cannot afford to go to the doctor.

Mr. THOMAS. And that is why we have a 90 percent of poverty starting line. They are the ones who get the most help at the very beginning.

Mr. DUNTON. Could I finish, Congressman?

Mr. THOMAS. Sure. Have you read the bill?

Mr. DUNTON. I have not read the bill, but I have listened to what you have had to say, and I am at the collective bargaining table practically every day of my life and I see this whole thing eroding before my very eyes over the last 10 years. And I see many, many of our members without coverage, yet the contract says they have it.

And if I am sitting there as a \$100,000 a year paid employer, I can well afford a \$2,000 deductible. Me, as the \$7.50 an hour worker, cannot afford that. So I opt right out of the plan. I have absolutely no coverage. My family has no coverage.

Mr. THOMAS. I understand all that and we provide it through a voucher.

Mr. PINKUS. Sir, I think you and Senator Chafee's bill most closely represents our position, because it provides for universal coverage through an individual mandate. You have subsidies for people who cannot afford to spend the money, and you provide for the voluntary competitive cooperatives so that small businesses can pool their buying power, yet we do not have a monopolistic government entity doing it.

To us it makes the most sense of all the proposals out there.

Mr. THOMAS. One of my concerns is that somebody here wants to make sure that government picks winners and losers. I think the best place that winners and losers are picked are in the marketplace in a structure that makes sure it is a fair fight, and I believe that is what H.R. 3704 contains.

I thank you very much.

Mr. PATRICELLI. Yes, Mr. Thomas, the Chamber finds a lot to like in the Chafee-Thomas bill. We like the voluntary alliance concepts, the approach to the tax cap, and we are interested in the individual mandate approach. We would like to work with you around what we understand to be two concerns on the individual mandate question.

One is, and I don't think it is addressed by your comment on collective bargaining, one would be the rather natural tendency on an employer's part to reduce their contribution so as to maximize the government subsidy for lower-wage workers. We wonder whether, in fact, the system can support the additional cost on the Federal Government that that might impose.

And the second is more of an administrative question, but an important one, and, that is, the means to enforce the individual mandate. But we remain very open to try to work those problems through with you.

Mr. THOMAS. Mr. Chairman, just let me conclude by saying the enforcement, I believe, is far better done with the carrot rather than a stick. And I agree with you and would love to work with you on that transition period in terms of the lower-wage workers, because those are the ones we need to make sure get the coverage the fastest.

Mr. GIBBONS. All right. Let me say that we intend to go on during this vote and the floor next goes to Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman. Sometimes there are rhetorical questions asked by the witnesses, and I want to answer one of them. The question was, where would Henry Ford have been if he would have had this employer mandate? Would it have ever happened?

Well, you know, that is a fascinating question if you look at history. The Germans have had a health care system since 1883. Now, I think that Mercedes Benz has been in existence at least that long, and somehow they have managed to produce some of the best cars in the world, and they have done it when they were paying an employer mandate on covering their employees.

So to suggest if we had had this employer mandate that American industry never could have moved forward simply does not face the facts around the world. I think that that has to be answered. That question is put out there and people say, oh yeah, well, gee,

it would not work. But it has worked. It has worked in other countries.

And one of the questions most interesting to me, and I would love to hear business people talk about it, those people who are paying taxes—excuse me, who are paying premiums for their employees—I can give you universal coverage in this country with a payroll tax on employers of 8.4 percent and 4 percent on small businesses below 75 people and a 2.1 percent payroll tax on taxable wages for the employees.

Now, most businesses are paying way more than 8.4 percent, if they are providing for their employees. I cannot understand why you would not want to take a more efficient system and use it than the one where you are paying—I mean, I always thought a percent here or there, pretty soon you are talking real money. That is the old Everett Dirksen line. Why would you not want a system if it worked for you with less cost to the employer or is it just ideological?

Mr. PINKUS. First of all, I lived in Germany for 3 years at Uncle Sam's expense in the 1970s, and I think there is a tremendous difference between what happens in Germany and what happens here in the United States. Because, first of all, when the Germans finish and do not need their low-wage workers, they send them back to Turkey. They do not keep them on under welfare and other systems. Their society is not open to immigration and Germany has not had near the job growth or economic growth over the long haul in the period we are talking about that the United States has, particularly in the last 20 years.

We have had much greater job growth here in the United States than the Germans have had as a percentage of our population.

As far as the fixed cost is concerned, our biggest concern with the mandates and fixed costs and fixed percentages is that they lack flexibility. Small businesses, in fact all businesses, need to have a certain amount of flexibility. Unless you can outlaw the business cycle at the same time, so that we can guarantee level economic growth and prosperity in all seasons, businesses have to have the ability to control their costs.

If you have all the costs fixed, and this is the direction that we have been going in recent years, if all the costs are fixed and they are all employee related, the only way that businesses have to control costs is not to hire people or to let people go.

Having been a small business owner, having had to face those choices numerous times over the last 20 years, I can tell you that that is one of the most painful decisions to have to make, is when business goes down and the money is not coming in and you cannot make payroll and you have cut all the costs you can control to the bone, the only thing else that is left is letting people go.

And I think there are a lot of people out here if you ask them would you rather have employer-paid health insurance or a job, they are going to answer a job.

Mr. McDERMOTT. Anybody else? Mr. Brennan.

Mr. BRENNAN. Yes, my comment on the European economy is similar to this gentleman's. If you look at job growth in the 1980s, it was basically flat elsewhere in the world but relatively strong here in this country.

But let me go back to your question. I don't really believe we are starting back in 1893. I think we are starting with a situation in which we have costs built into businesses. In other words, whatever costs we have in our businesses—occupancy, payroll, benefits—are all part of our cost factor.

If you consider the retail industry, which employs, as I said, 20 million people—mostly people who are starting their first jobs, working part-time, and working at other jobs—you have to take into account a different economic model. As I said earlier, the average retail employee contributes \$1,740 in annual earnings to its company; the average manufacturing employee, \$6,500. Thus, in retailing, there is an entirely different relationship between costs and earnings compared with manufacturing.

Now, one could say just shift health care costs over to those who are not paying their fair share. But I would submit to you that when you have shifted those costs, when you have added \$17 billion to the retail industry, that industry has no other option but to reduce jobs. I think that is a large economic factor, sir.

Mr. McDERMOTT. Let me ask a question, then. Let's say you put this in as a fixed cost, that means that everybody making widgets has this fixed cost in the price of their goods. That then takes it off the table as a reason why a business should fail for that reason. They may fail for some other reason, because their marketing is rotten or their customer service is bad or a lot of other things, but it is not the cost of a health care plan that is universal across the table.

Mr. BRENNAN. Well, your assumption is that consumer buying patterns would change immediately. In other words, you are saying that if you shift health care costs over to the low-wage associate, or employee in this case, you can raise your prices proportionately and consumer demand will remain the same. That just does not work.

If you take an average product we sell and increase its price by 20 to 25 percent, the demand for that product will drop at a faster rate, by 30 to 35 percent.

My only point—and, once again, we support health care reform—my point is that such a dramatic shift in costs would have a major economic impact on an industry that employs 20 million people and another 10 million who support that industry. About 30 million out of 100 million U.S. workers are associated with the retail industry. So it is not the case that retailing does not want to help our employees secure the benefits that we have talked about earlier; it is a matter of simple economics.

Mr. McDERMOTT. What is the percentage on the retail industry that you spend on health care costs?

Mr. BRENNAN. As an industry, it probably averages around 6 percent.

Mr. McDERMOTT. That is because most employers are using lots of part-time people.

Mr. BRENNAN. About half of our employees are part-time, that is correct.

Mr. McDERMOTT. And you do not cover them?

Mr. BRENNAN. Of those employees, a great majority are covered by their families, or covered through other primary jobs they hold. They are not uncovered to the degree you are suggesting.

Mr. McDERMOTT. Do you know that? Are you asking them?

Mr. BRENNAN. We have taken surveys; yes, we ask.

Mr. McDERMOTT. So if they are covered by somebody else, then you say we can make them a part-time worker?

Mr. BRENNAN. Absolutely not. What I am saying is that employees have the option. So we know which employees opt to take benefits and which do not. But if you are suggesting to me that we hire or do not hire people for that reason, I would disagree with you.

Retailing gives most Americans their first jobs. We train them, in accord with their preferences we turn them over three times a year, and they go on to other jobs. We are very dedicated to building a work force in America. Many people on this committee, I would think, had their start in retailing.

Mr. McDERMOTT. I did. I worked for the Jewel-T Store in Chicago a long time ago.

Mr. BRENNAN. OK.

Mr. McDERMOTT. I understand that. But what I am suggesting is that you cannot get universal coverage if you do not build in the fact that everybody has to be covered. And Mr. Pinkus suggests you have to let each business have the option that, if they are in trouble, they can cut out the health plan. That occurs today and that is exactly our problem.

So that is why if you are going to get universal coverage you have to say to everybody we have to put it in. Mr. Stark, unfortunately, is not here, but I am really following up on his point. If you raise the minimum wage enough to make this 2.1 percent we put in the single-payer plan, you have got the money to give a health care plan.

And my view is if you put that in, you level the playing field. If every restaurant raises the cost of a meal a few, maybe half a buck or whatever it amounts to, people are not going to stop eating out. You are saying what happens is that people stop eating out or they do not buy refrigerators. They are going to buy those things. They have to.

Mr. PINKUS. They do not eat out as much. Every product has a threshold at which people stop buying. I just talked recently with one of our members who is in the dry cleaning business. When the price of laundering shirts goes up above \$1, the number of shirts he gets to clean goes down. And he knows exactly where those numbers are. And when the number of shirts that he launders goes down, he needs less people.

Mr. McDERMOTT. So when the cost for soap goes up—

Mr. PINKUS. As you raise the cost for labor, you raise the cost for goods and you lower the demand for labor so you have less need for jobs. And we are not talking about getting rid of health insurance plans. What we are talking about is really eliminating jobs if you make the cost of jobs too high.

Mr. McDERMOTT. That is the only cost you can get rid of. You cannot get rid of the cost of soap and you cannot get rid of the cost of electricity and you cannot get rid of the cost of buying washing

machines in that laundry. So the only thing you can get rid of is this health care plan; right?

Mr. PINKUS. There are—

Mr. BRENNAN. There is a great deal of discretionary merchandise purchased.

Mr. McDERMOTT. Unfortunately, I have to go vote. We will see you again.

Mr. RANGEL [presiding]. Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman. What I would like to do is talk about the entire fairness of this issue, which no one has really touched upon. We are told that about 80 to 85 percent of Americans are currently covered under an employee-based health insurance system. So, we have to think that the bulk of the employers in this country, for various reasons, such as social responsibility or bargaining are covering their employees.

What the President does, and I think here lies the ultimate fairness of the President's proposal, he says all employers should provide coverage. If in fact the bulk of them can, why shouldn't the balance? And in the current situation—and we will get to the Kip example, Mr. Pinkus—the large employer who offers a plan usually picks up the family coverage and the other employer employing the spouse gets a free ride. All right?

I am assuming the business groups here are all against welfare, these people who are on our backs getting a free ride. OK?

Mr. PINKUS. Yes.

Mr. KLECZKA. It is abhorrent and you folks are always out there talking about it. But how about your colleagues in business who are getting the free ride? Let's address them for a moment.

If we use the Kip situation with the working spouse, or the working wife, I assume she has health care coverage. And if there are kids it is family coverage. So Kip is sitting back there with his two employees offering no coverage to his employees, but he has it himself because, in all probability, his wife's employer is covering it.

Now, can you folks from business tell me the fairness of that? Why should the employer with the deep pockets subsidize the employer who, (a), does not offer it; or, (b), offers an inadequate plan?

If you can succinctly tell me why that is a fair system and why you folks with the Chamber, the big pocket folks, the ones who do most of the coverage in this country, why are you not obsessed and objecting to that current system?

Mr. PATRICELLI. Congressman, first of all, the Chamber's membership is made up of 96 percent of companies with 10 or less employees, so, in fact, it is not the deep pocket folks.

Mr. KLECZKA. And what percentage of your members have health insurance?

Mr. PATRICELLI. The majority have health insurance.

Mr. KLECZKA. Fifty percent?

Mr. PATRICELLI. More than that. We do not know precisely, but something on the order of 70 percent, we believe.

Mr. KLECZKA. Fine.

Mr. PATRICELLI. Now, there is a concern about fairness, but at the same time business people know that fundamentally a small, low-wage employer, while he may be being unfair to the employer of his employee's spouse by not covering him or her, if that em-

ployer cannot maintain his job structure and at the same time pay for health insurance, that would be a bigger unfairness. There is a cost shift.

Mr. KLECZKA. So the larger employer, in your estimation, accepts this responsibility for the brethren?

Mr. PATRICELLI. He does not like it, sir, but we have to understand that pure fairness has to be balanced against other things.

Now, there is, I believe, about \$10 to \$12 billion in intercompany cost shifting that goes on from those that do not provide coverage to those that do. That number is, I believe, according to the estimates, less than half of the cost shifting that goes on from government underfunding its payments to Medicare and Medicaid recipients to business.

So if we are going to talk about the fairness issue, we should start with the government programs not with strapping small businesses.

Mr. KLECZKA. So let's not talk about the unfairness going on in industry now because government is a bigger abuser. I don't accept that as an answer.

How about the situation where one company offers a Cadillac plan, a family plan, and the other employer, who might be as large, just for whatever reason, offers a leaner health plan. The employer with the Cadillac plan is the one that has to have the responsibility. Is that fair between the two employers?

Mr. PATRICELLI. Presumably, in the absence of governmental mandates and requirements, that larger employer has made the judgment that that richer plan helps him attract the kinds of employees he wants to have and he is prepared to sustain that cost.

Mr. KLECZKA. When we talk about free rides around here, let's make sure that you folks are consistent. You have no problem giving a free ride to your brethren, but God forbid the government make that system a level playing field or provide for some fairness there.

Mr. PATRICELLI. You would not propose leveling compensation among employers. Why would you want to level health benefits?

Mr. KLECZKA. Why should I, as a large employer, even offer it? I should be the slouch, like my neighbor, and just say no. And then we would really be in a pickle in this country, wouldn't we?

Mr. PATRICELLI. Virtually all larger employers do offer insurance, and we believe what the committee should try to do is to build on the current system.

Mr. KLECZKA. That is exactly what the President's bill does. It is not socialized medicine. We take the current system and we build on the employer-based system. That word is not getting out because you folks, I guess, do not want it to get out, plus I am always unsure of your position because we keep getting all these statements and they keep changing bottom lines.

I have to go vote also, so I am exiting the committee. Thank you, Mr. Chairman.

Mr. RANGEL. Mrs. Johnson.

Mrs. JOHNSON. Certainly fairness matters a lot, and years ago we had basically the same benefit plan at a community-rated cost, and we had a lot of fairness. And one of the reasons it is important to recognize that is to recognize that rising costs destroyed equity.

And if we do not address the cost issue, it does not matter if we recreate equity in 3 years or 5 years, it will be gone.

In that regard, I would like to hear your thoughts on two aspects of this mandate: Will it affect private sector investment and cost control; and how serious a matter do you think that is?

In other words, if a company's bottom line is not affected by what they do about health care—in other words, if health care is no longer a variable cost but a fixed cost determined by the government—will companies continue to invest in health care cost control efforts or not? That is one important issue.

A second important issue, from your experience, do you foresee a mandate having the same impact as some of our tax changes have had in the past; that is driving a purely legally driven reorganization of our economy?

Do you think, to be precise, that the mandate will result in—and this is particularly important for you, Ms. Connerton, because I have every reason to believe this will happen; and, as a woman, I am very concerned about women's opportunities in our society, and I am very concerned about this aspect of the mandate—a bifurcated premium structure, which is absolutely essential to the mandate because small businesses simply cannot afford the cost of big businesses, will lead any sensible small business to spinoff its low-paying jobs into small 25-member companies and then contract with that company for the same service at a lower cost? Because they will only have a 3.5 percent health care cost, and the major company will have a 7.9 percent health care cost. So the large company will think through how it can spin these things off.

Now what that does to the people working in those companies, most of whom are women, is to give them no role models, and no career ladders, and no salary opportunities. And if you do not think this will affect the structure, if you do not think this will create a new round of downsizing, then you have to give me a good reason why you think that is not going to be true; and you have to give me the economics of why you think it is not going to be true.

So these are two important economic consequences of the mandate, which if you cannot convince me will not happen, I cannot support a mandate. I can support an individual mandate, not a mandate on business. You have to convince me that restructuring will not happen; you have to convince me that somehow the private sector will remain willing to invest in cost control. Because if they do not do it, the entire responsibility and power will shift to Congress.

And I am a member of the committee that tries to control costs in Medicare, and I can tell you our record is awful. And in Medicaid it is worse. In the VA system it stinks. In CHAMPUS it is bad. And only in the public employee sector, because we are trying some of the things that the private sector is trying, are we making a little progress.

So on those two issues, please. Mr. Patricelli? Either one of you. Mr. PATRICELLI. Well, I will start on the first one, Mrs. Johnson. You asked the question as to whether the mandate structure, and I think particularly the President's bill, would maintain or destroy private sector initiative for cost containment. And that is one of our biggest complaints about the structure of the President's proposal.

He talks about maintaining the private employer-based insurance system, but in fact he radically reforms it, converting the employer's role into merely one of providing dollars and taking away any ability or incentive to affect the cost. No wonder so many employers object to that kind of a mandate, when you are asked to pay but at the same time you lose incentives and controls that you now have.

The particular problem in that regard, as you know, is the idea that roughly 90 percent or 95 percent of the nonelderly population would be forced to get their insurance through these large regional community-rated pools.

Now, by depriving most employers of the ability to have access to a self-insured arrangement where they get the benefit of their own cost containment and wellness and prevention activities, you have pulled the pins out from under the private sector cost containment, which in fact has produced the dropping premium costs that we have seen over the last couple of years.

So there is an absolutely, in our view, unnecessary diminution of the employer's incentive and role that has accompanied this President's approach to the mandate.

Mrs. JOHNSON. Thank you.

Ms. CONNERTON. Let me say from the other side that we have a different view on this, and in fact labor-management has spent most of the 1980s working together to pioneer some of these techniques, like managed care and utilization review and so forth.

Mrs. JOHNSON. Also profiling claims to identify workplace health problems, which costs a lot of money.

Ms. CONNERTON. Right. We have become much more sophisticated at what our health costs are and so forth. And, unfortunately, I think that the conclusion that we have reached is that attempts to do it alone employer by employer simply have not worked. They may work for a short period of time, but they do not work in the long run and that what you need is more system-wide cost controls.

I think that although the health alliance approach of organizing the market, engineering competition between health plans is going to go a long way to accelerating, if you will, some of the early innovations that labor and management started.

Mrs. JOHNSON. Ms. Connerton, I absolutely agree with you, but you cannot do it company by company.

Ms. CONNERTON. You cannot, because if you are successful like we are with—

Mrs. JOHNSON. But let me just say—I am sorry, Mr. Chairman, I will be done in just one sentence. If your payroll ties cost money, then all of that work you and management have been doing will stop being done. No company will invest in what it costs to profile claims to find workplace causes of health problems.

So while managed competition has some promise, it does not have any promise if the companies involved are not going to benefit from the savings. This is the larger issue, and I am very sorry that on this issue Mr. Dunton, Mr. Brennan, and Mr. Pinkus did not get a chance to speak, and if there is a second line of questioning, I will do it, because the restructuring issues are very important.

And I think that many of us share your goal of universal coverage, and we can get there.

Mr. RANGEL. The time of the gentlelady has expired.

Mr. Kopetski.

Mr. KOPETSKI. Thank you, Mr. Chairman. I did not give an opening statement and so this will be in part an opening statement, and I will finally get to a question, I am sure.

I do want to agree with my colleague and classmate from Pennsylvania, Mr. Santorum, that we do have the best health care in the world, that is, we Members of the U.S. Congress. Of course, we get paid \$133,000 a year. The problem is that if you examine who does not have health care coverage in this country, three-fourths of the people who are not covered under a plan are in a family where there is a person working at a job in this country. So when we look at this, how do we extend coverage to those people?

I think the President is correct that the first place we should go is to the employers in this country. And as Mr. Kleczka has rightly pointed out, our health care system is based on an employer-related system, except for the retirees, of course. Most people get their health care coverage through their employer.

And Mrs. Johnson was right in her opening statement also when she said this is a very important hearing for this committee, one that we have all been looking forward to. The chairman put out a press release December 21, 1993, saying we are going to have this hearing, the Chamber's request to testify was confirmed probably around—at least 2 or 3 weeks ago.

And, frankly, Mr. Patricelli, I am very disappointed. I am disappointed because you are not telling us what you are for. Yesterday, we got this nice multicolored copy of your testimony and then today we get a totally different version. And it is just odd to me that something so critical to the business community, to the people of the United States, that for some magic reason last night at the eleventh hour you chuck this and insert this.

I don't know what happened yesterday, but something obviously must have to have this important change in your approach to today's most important hearing. In today's testimony you talk about your current position, and for a member of this committee, when you say the word "current position" that means it is subject to change tomorrow.

And you guys are really important. You are well respected. We worked together on NAFTA and all kinds of important issues to this country, and then you come in here on this critical issue and you say, well, we have changed from last night and we have a current position and we do not know what our position is going to be tomorrow.

Then in your testimony today you say you will be blunt. Well, that is very nice. That is page 1. Page 3, you say, well, we are currently reexamining, dot, dot, dot, alternatives.

This issue has been around forever. It has been peaking. The President has put it on his agenda from the campaign and day one of his administration, and you are not helping us out. I think you are doing a disservice to the President, Mrs. Clinton, who has invested a lot of her time and effort and resources into this issue, and to the businesses you represent. It is not helpful. It tells us a lot about what you do not like, but does not tell us what you are for

and how to solve these problems that are facing you as a business representative.

The fact is that 14.6 percent of our GDP is going to health care coverage. If we do nothing, it is going to go to 20 percent by the year 2004. If we adopted the President's plan, it will go to 19 percent or something else, we hope, and will keep it under 20 percent.

We do not have a choice. If we want to be competitive, we have to do something. And you guys, your businesses, spend a lot of money on their dues for you to come here and give us your best advice and you did not do it. You did not do it.

So my question, really, is for Mr. Pinkus because——

Mr. PATRICELLI. Well, I trust I am going to have a shot at responding to that.

Mr. KOPETSKI. Well, I hope so too. I have to say, for some reason, people think that health care costs only went up 2 percent more than the rate of inflation and somehow this is a victory. This is not a victory. There is still a problem out there. And my cynicism says the only reason it does not go up even more is because the industry is afraid government is going to do something, that maybe they should keep the increase down.

We can all revel in that. It saves you guys some money and everything, and that is well and good, but the fact is if we go away from this problem, who knows, there will be a 10 or 12 percent increase next year.

My question really is for Mr. Pinkus.

Mr. Pinkus, what percent of your payroll goes to health care coverage?

Mr. PINKUS. Of our payroll—I run an association that has one employee, so right now, nothing.

Mr. KOPETSKI. What do you think the average is for your industry?

Mr. PINKUS. We do not have an industry, we have a cross-section of small business people in Texas and we have tried—the percentages really are, frankly, meaningless because they are in so many different industries. And when you try to come up with a percentage, you know, I think it would be difficult, and then what does it mean. Because I have accountants, lawyers, plumbers and janitors as members, so what do those statistics mean?

Mr. KOPETSKI. Because it is a very important aspect of the President's plan. There is a cap under the President's plan of 7.9 percent or less for small businesses. It seems to me it is very simple arithmetic, if I were a businessman, to see what this cost is.

Mr. PINKUS. If you, Congress, pass an employer mandate with a subsidy, and you have the kinds of stairstepped caps that are in the bill, I guarantee within 24 hours of the bill passing, every CPA and business consultant in this country will have put together a program on how you can restructure your company in order to get the maximum subsidy. And the subsidy will get so big you guys will be back here in a year or two trying to figure out how to reduce the subsidy.

So there is nobody in our association—and if you look at Vice President Gore's comments on reinventing government, you will see 70 percent of the people in the United States do not have faith in the government's ability to do the right thing. We do not believe

if you say today there is a 7.5 percent cap, if you say that today, we know that tomorrow it will be something else.

Mr. KOPETSKI. You can come here and fight that, then. But I tell you, keep in mind the government—we are the government, you and me.

Mr. PINKUS. That is why we are here.

Mr. KOPETSKI. Exactly right. You are part of this government process. So you have to be connected to this if you are going to have a change involved.

You have to examine what the costs will be and you have to fix the problem, and the problem is you are getting eaten alive as a business with health care costs.

Mr. PINKUS. We support health care reform.

Mr. KOPETSKI. Well, good. Tell us exactly what it is.

Mr. PINKUS. I did. I did. We support an individual mandate. That does not mean employers would no longer be providing health insurance, but we think mainly because of the need for flexibility, and also in order to be able to identify who you subsidize because you can best identify who needs to be subsidized by looking at individuals because you can determine what their income is.

But if you look at businesses and you go by business size and average wages, you go through all kinds of hoops and loops in order to try to figure out who to subsidize and who not to subsidize.

Mr. KOPETSKI. I am out of time. I gave you the last word.

Mr. PATRICELLI. And you are denying me the time to respond to your comments?

Mr. KOPETSKI. It is up to the chairman.

Mr. McDERMOTT [presiding]. We will give you 1 minute.

Mr. PATRICELLI. I would like to submit 4 detailed pages of principal health care reform that represents the Chamber's position. You have not seen that and you are criticizing us as not having detail. I am happy to share it with you.

[The following was subsequently received:]

U.S. Chamber of Commerce Guidelines for Health-Care Reform

The Board of Directors of the United States Chamber of Commerce urges the Congress and the Administration to enact comprehensive, market-based health-care reform. The Chamber is the world's largest federation of businesses, associations, and local and state chambers of commerce.

Based on a poll of its entire 220,000 members, the Chamber Board has adopted an eight-point framework for health-care reform. This framework is built upon the principle that reform is best achieved by enhancing our current employer-based insurance system through highly targeted, market-oriented steps that collectively will produce comprehensive change. While the health-care system does have significant problems, it serves most of our population well, and we must be careful not to undercut its strengths or to interfere with the positive trends under way.

The broad objectives of reform should be to decrease the rate of growth of health-care costs, to achieve better equity in the spreading of those costs, and to increase access to health insurance and quality health care. To accomplish those objectives, the Chamber proposes the following eight guidelines under three categories—enhanced competition, insurance market reform, and medical malpractice reform.

A. Enhanced Competition

Cost containment and improved quality should be achieved through enhanced competition. More cost- and quality-based competition among health plans is the best strategy for cost containment and quality improvement, rather than increased reliance on government regulation and price controls. To enhance a market-based, competitive system of health care, we need:

1. A nationally defined standard benefits package that all health plans must include. Only with standardized benefits can buyers—both businesses and consumers—properly compare prices among plans. The standard package should:

- provide coverage only for medically necessary services.
- provide access to comprehensive services with significant consumer cost-sharing deductibles and co-payments to discourage unnecessary use of services.
- pre-empt state benefit mandates.

2. Required posting by all health plans of annual prices for insured members as well as data on quality and service published in a common format, so that employers and consumers can make informed choices.

3. Preservation of consumer choice in combination with greater accountability. Consumers should be able to choose from a range of health plans. They should be able to save money by selecting a lower-cost plan and should participate (via deductibles and co-payments) in the cost of medical services.

4. 100% tax deductibility of health-insurance expenses for the self-employed.

5. Simplified administration. The cost-effectiveness of a market-based system can be improved through government encouragement of simplified and standardized processes for health plans and consumers, including:

- requirements for common claims forms.
- enhanced electronic-data interchange between providers and payers to eliminate paperwork.
- support for standardized clinical protocols and computerized patient records.

B. Insurance Market Reform

Both cost containment and improved access must be achieved through insurance reform. Medical underwriting by insurers and the fragmentation of risk pools have resulted in higher costs and reduced access for large numbers of Americans, especially high-risk individuals and employees of small businesses. In addition, the widespread practice of denying coverage to those with pre-existing conditions has made it difficult for many insured workers to change jobs, resulting in job-lock. To deal with these problems, we should:

6. Enact comprehensive insurance reform at the federal level. This legislation should provide that:

- all health plans (insurers and HMOs) must accept and renew all applicants regardless of health status (guaranteed issue).
- pre-existing condition limitations are prohibited (portability).
- premiums for individuals within groups may not vary with health status (bans individual medical underwriting).

7. Establish voluntary purchasing pools for small employers and individuals. Even with the aforementioned market and insurance reforms, small employers and individuals would lack the purchasing power and lower administrative costs of larger groups. To deal with this, states should permit formation of purchasing cooperatives to assist small employers and individuals seeking to purchase health plans.

C. Medical Malpractice Reform

8. Medical liability reforms must be a critical part of any health-care legislation. Both cost containment and quality can be enhanced by reform legislation that provides for:

- limits on recovery of non-economic damages to \$250,000.
- mandatory offset of collateral sources (e.g., health insurance and disability benefits).
- structured payments of malpractice awards instead of lump-sum payments.
- pretrial alternative dispute resolution, including mediation and pretrial screening.
- adoption of basic criteria for medical expert witnesses.
- limits on contingent fee awards of 25 percent.

Mr. PATRICELLI. You asked whether or not there is support for a concept of shared responsibility or mandates. The Chamber has not rejected that out of hand. Rather than attacking us for not having a specific proposal, you might find some support for the idea that we have not rejected it out of hand.

What is happening in the business community is that support for that concept is eroding because all mandate proposals are so encumbered with costs and regulatory burdens that businessmen are saying this cannot work. That is what is happening.

Mr. KOPETSKI. The fact is you do have mandates.

Mr. McDERMOTT. Mr. Kopetski.

Mr. KOPETSKI. Thank you, Mr. Chairman.

Mr. McDERMOTT. We have a long hearing.

Mr. Levin will inquire.

Mr. LEVIN. Thank you.

Mr. Brennan, let's zero in on your specific testimony, OK, because I have met with some of the members who have raised the productivity issue. Do you know what percentage of earnings today in the retail industry go for health care or what is the proportion?

Mr. BRENNAN. The percent of our earnings would be about 40 percent; of payroll, about 6 percent—and that includes, of course, full-time and part-time employees. In other words, if we make \$100 million, health care costs over \$40 million, and that is about typical for the industry.

Mr. LEVIN. Yes, in your case. And that includes all employees?

Mr. BRENNAN. That is a combination of those covered and not covered. That was my point.

Mr. LEVIN. So when you make these calculations, you include all employees?

Mr. BRENNAN. Well, you asked what health care costs as a percentage of total earnings, and that is what it is. As a percentage of payroll, it equals about 6 percent.

Mr. LEVIN. Six percent. So let me ask you this. In some cases, obviously, manufacturing exceeds the 40 percent. There is a lot of heat on this issue and I am afraid not often enough light.

This whole issue is one of shared responsibility. We are talking about an employee sharing responsibility, and I am in favor of that and phasing out over a number of years plans where there is no employee responsibility. So let me ask you this. If we tailor a plan so that employer contribution was more reflective of earnings and of payroll than in the President's plan, and they made an effort through the 7.9 percent cap, will the retail industry support such a plan?

Mr. BRENNAN. I will answer that, but let me make one comment first. You used the term "phase-in." "Phase-in" implies something very favorable. If someone criticizes the plan as too rich, the response is that the plan will be phased in. I think it is important to note that, in this case, the "phase-in" actually is detrimental, because employers pay the full amount until the eighth year, when the 7.9 percent cap takes effect.

Mr. LEVIN. I fully understand that.

Mr. BRENNAN. But I want to make sure everyone else does, because I think it is a very important point.

Mr. LEVIN. Well, we can change that, and there was an effort at least to try to bring some kind of equity among employers. And maybe it takes too long a time, but we can work on those important details.

So my basic question to you is again this: If there is a requirement of shared responsibility not only on the employee but on all employers that is fairly reflective of earnings, of payroll—I cannot give you the exact formula—will there be some circumstances under which the retail industry will accept a responsibility to cover all employees?

Mr. BRENNAN. Well, first of all, any percentage lower than what we have before us today would be more favorable. I mean that is obvious. We want to be certain we have access for everyone, but in terms of direction, I would say yes. As you just said, we can take care of the phase-in. We can also take care of proration. But the mandate as written today has a number of major problems in it.

Mr. LEVIN. I understand that.

Mr. BRENNAN. Before I could agree to a percentage, it would be necessary to understand all the elements of a plan. We cannot just say 3 percent is OK, or 4 percent is OK.

We are dealing with a plan that is highly confusing. When you get into it, you see that there are double costs, not just for retailers but for other companies. I think it is important, sir, for us to understand all the pieces.

Mr. LEVIN. I understand. But just so I am clear about your answer, conceptually there are some circumstances under which you would accept and support or at least accept a requirement that the retail industry employers cover their employees with employee participation?

Mr. BRENNAN. Well, I would make one other point which you did not address—it is part of the answer—and that is that mandates have larger problems than cost. The issue is whether a business can do a better job of reducing and managing its costs than the government can.

So, number one, we are opposed to a mandate; second, to address your question, we would review any alternative plan you propose, but I don't have a definitive answer today because I don't know what your plan is.

Mr. LEVIN. No, but if you say you oppose any mandate, you are saying, unlike the Chamber, there are no circumstances under which you would accept a proposal that would require the employers in the retail industry to cover all employees with employee participation? You are saying under no circumstances.

Mr. BRENNAN. Let me tell you what I am saying. Since I met you last in this same forum, I have heard a number of other iterations of this plan. Mr. Stark talked about one earlier today, and you are talking about an alternative now. There have been a lot of changes in various plans. I am here to listen today, and to communicate. We are willing to have a dialog with you about different options, but for me to commit to a plan today would be premature.

Mr. LEVIN. The red light is on, and I want all of us to try to keep to our time allotment. I am not trying to get a commitment to a plan. What I am asking you is whether you can, under any circumstances, as the Chamber policy says it could, accept a plan

where there was required participation by all employers and employees; yes or no?

Mr. BRENNAN. And my answer is, not until I better understand your plan.

Mr. LEVIN. So there are no circumstances or there are?

Mr. BRENNAN. I am saying to you, again, not until I understand the plan. We would like to work with you, as I told you when we met last time. We would like to sit down and participate with you in the process. This is not a matter of big business or small business against government. It is something we both have to do, and that is my answer, sir.

Mr. LEVIN. I fully accept that spirit. All I am saying is it is hard to bargain or discuss—forget about bargain—when a party comes in with a position no to start with.

Mr. BRENNAN. It is interesting that the Business Roundtable made an announcement yesterday about its position. We chose to come in here, I chose to come in here, with an open mind. I want to have a dialog, and that is why I am here.

Mr. LEVIN. Great. OK.

Mr. BRENNAN. Thank you.

Mr. LEVIN. Let's proceed with that spirit.

Mr. McDERMOTT. The time of the gentleman has expired. I believe Mr. Bunning will inquire.

Mr. BUNNING. Thank you, Mr. Chairman, very much.

I would like to inquire of Mr. Patricelli—that is with an "A," isn't it? Not a former shortstop with the Red Sox.

Mr. PATRICELLI. Patricelli, correct.

Mr. BUNNING. Is there any circumstance or has the Chamber board come to a conclusion that under any circumstances they would agree to some type of employer mandate in any kind of health care plan?

Mr. PATRICELLI. As far as we have gotten on that, Mr. Bunning, is to say that we have not rejected mandates, individual's or employer, out of hand as a matter of principle. We have yet to find one we like and can accept.

And part of the difficulty with a hearing like this, which focuses on a single issue is that you cannot look at the issue of financing or of shared responsibility without, as has been said here, knowing the whole package. So we cannot deal on a piecemeal basis, but we do not rule it out as a matter of theology. We are not enthusiastic but we do not rule it out.

Mr. BUNNING. Just to followup. We are trying to come to some kind of conclusion or some kind of idea of how to pay for what we want to produce and this is one of the methods that has been expounded upon in different plans. One is an individual; one is a small business or business mandate. So there are circumstances that a portion of the business community would pay for something, some portion of this plan, even if it were an employer mandate.

Mr. PATRICELLI. We do not rule that out.

Mr. BUNNING. I would like to ask the representatives of the AFL-CIO their understanding of the President's plan in regard to union contracts that have already been negotiated. How do you understand the President's plan deals with them?

Ms. CONNERTON. Our understanding is that plans that are negotiated to the extent that the covered benefits or cost sharing requirements are more generous than the comprehensive benefit package; that those arrangements could continue on a voluntary basis through the process of collective bargaining.

Mr. BUNNING. For how long?

Ms. CONNERTON. Well, there is a difference in tax treatment of supplemental benefits after the year 2004.

Mr. BUNNING. Ten year program? In other words, you would be sort of exempt from being included in this program for 10 years?

Ms. CONNERTON. No. In fact, it is an arrangement that can be made not just in situations where there are unionized companies but in nonunion companies as well since this benefit program operates like the minimum wage. So that anything that voluntarily is negotiated through the compensation package, can continue so that nonunion employers can provide supplemental benefits if, in fact, they so choose as well.

Mr. BUNNING. And certain types of corporations that have so many more employees than 5,000 are also able to be excluded or, as you would say, voluntary excluded? In other words, if I have a corporation that employs 5,000 people—

Ms. CONNERTON. Five thousand or more full-time employees; that is correct.

Mr. BUNNING. And my question is, you are supporting the President's plan, and I am looking at the members of the panel here and all Federal employees, union employees who have preexisting contracts and certain major businesses of 5,000 employees or more, and if this plan is so good for America, why are we making exceptions for each and every one of those people?

Ms. CONNERTON. Well, first of all, let me say that in terms of our contracts, in many areas we will actually receive better benefits under the Clinton package than what we are able to currently negotiate.

Mr. BUNNING. So you would voluntarily choose not to exempt yourself?

Ms. CONNERTON. It is—no, no. We are not exempted. It is a different concept. Everybody is guaranteed the basic package. And many of our employers will choose to go into the regional alliance because our members do not work for large corporations. So they will be in the regional alliances. But through the process of collective bargaining, if they so choose, they can negotiate additional benefits.

Mr. BUNNING. Mr. Dunton.

Mr. DUNTON. Let it not be said that all of the AFL-CIO unions are supporting exclusively the Clinton plan. Our union is supporting H.R. 1200. We believe the single-payer system is the best. And we are obviously in favor of the universal coverage because we see what we have got slipping away before our very eyes.

But never in my wildest dreams, in the 30 years I have been at this, since the days I left the shop, did I ever think I would hear an employer say at the bargaining table that the moneys that we have put up to have the health coverage that we have got, belongs to the employer. And more and more they are saying that. And that is something that needs to be considered.

If we have a buck an hour on the table to pay for our coverage, it belongs on that table to be divided up, not given back for us to have inferior minimum standard coverage in this country.

Mr. BUNNING. Thank you, Mr. Chairman.

Mr. McDERMOTT [presiding]. The gentleman from Nebraska, Mr. Hoagland, will inquire.

Mr. HOAGLAND. Well, thank you, Mr. Chairman.

It sounds to me like all of you who are representing, especially the business community this morning, agree on the goal of insurance reform.

Mr. Brennan, your statement on the first page, while you favor insurance reforms which would eliminate the preexisting exclusion and guarantee availability of renewal and portability of coverage; and, Mr. Pinkus, your statement, somewhere, if I can find it, NSBU is highly supportive of comprehensive health care reform and inclusion of universal coverage; and Mr. Patricelli—

Mr. PATRICELLI. We would support that, Mr. Hoagland.

Mr. HOAGLAND [continuing]. Your statement indicates that all individuals should be required to have health insurance which should be paid for through a combination of employer-employee contributions for all working people and dependents, and a few things I left out.

So the consensus is we need to achieve the goal of small group reform, and all of you agree there should be mandates. In other words, everybody has to be in the system or it will not work; you cannot community-rate unless everybody is in the system.

Mr. Pinkus, you are shaking your head yes. Mr. Brennan—

Mr. BRENNAN. I didn't hear what you said.

Mr. HOAGLAND. We cannot accomplish that stated objective that all three of you have put into your statements without bringing everybody into the system through a mandate, either an employer mandate or individual mandate.

Mr. BRENNAN. No, I did not say that. I believe that the first thing we need to do is reduce the costs. I went through a difficult situation myself, to turn our company around. I dealt with reducing expenses before making investments. I think the cost issue has to be dealt with first in this case before we determine as well, that a mandate is necessary.

Mr. HOAGLAND. Well, let me ask you. You are the CEO of Montgomery Ward, chairman of the board.

Mr. BRENNAN. That is correct.

Mr. HOAGLAND. But is there any way we can achieve small group insurance reform, a policy all Americans can take with them job to job, place to place without bringing everybody into the system through mandates?

Mr. BRENNAN. I don't believe that we have to have mandates. I believe we have to deal with the kind of issues that we have talked about—defensive practices for physicians, and all the rest. We should address those issues first, and then determine what the needs are before we make a blanket statement that a mandate is required.

Mr. PATRICELLI. May I comment, Mr. Hoagland?

Mr. HOAGLAND. Sure.

Mr. PATRICELLI. In fact, it is possible to achieve insurance reform and community rating in the small case market without a mandate. In fact, we used to have and still do have in some parts of the small case market community rating. The costs of small businesses who are not insured, the health care costs associated with that population and the costs of those that are, are approximately the same.

So it is not a matter of achieving an adequate risk pool. You do not need to mandate uninsured companies to achieve an adequate risk pool.

Mr. HOAGLAND. But we need to get their employees into the system somehow, don't we?

Mr. PATRICELLI. We have small case coverage now. It is not as good as it could be because of some of the insurance regulatory and medical underwriting problems.

Mr. HOAGLAND. If healthy individuals can opt out, why then you get caught in a downward spiral, don't you? Like we have in New York right now. I think your oral statement now may be inconsistent with what you are saying in your printed statement.

Mr. PATRICELLI. No. In our employer-based system now healthy individuals can opt out. Few employers have a requirement that every employee must accept coverage.

Mr. HOAGLAND. We do not have portability now, either.

Mr. PATRICELLI. Well, that we can change with insurance regulation. This does not require every employer to be required to participate, sir.

Mr. HOAGLAND. Check with your members from the insurance industry. The risk adjusters will tell you that unless you get everybody into the system, you cannot community rate.

Mr. PATRICELLI. Well, I spent 10 years in the insurance industry—I am happily out now—and I would respectfully disagree.

Mr. HOAGLAND. Mr. Pinkus.

Mr. PINKUS. Let me point out that in Texas, we passed a bill in our legislature that provided for portability and guaranteed renewal without a mandate. So you do not have to have the two. Where you run into the real problem is with guaranteed issue; where you have to accept everybody. Because we still allow medical underwriting.

And there is a plan that is on the table I think that our Senator Gramm and Representative Arney have put together that does not have a mandate but the incentives or the penalties for not having insurance if you can afford it are pretty stiff, which would cause people to want to have insurance, I believe. So there is a carrot and a stick approach.

But whatever is done, I think that the administration, in going through the whole problem and looking at the system reforms that are needed to get everybody coverage and have portability, really indicate you have to have everybody into the system. Otherwise, as in New York where we have guaranteed issue, people under the age of 40 are five times more likely not to buy insurance than people over the age of 40.

So it is a perceived need, and without some type of mandate or strong incentive to force people into the system, you have adverse selection and the cost of insurance just goes through the roof.

Mr. HOAGLAND. My time has expired. I appreciate your saying that, Mr. Pinkus. That is what your statement reflects; that we should have an individual mandate.

If Mr. Brennan or Mr. Patricelli, if you can get us to small group reform in the guaranteed issue without a mandate, why, please, I would be most interested in knowing how to do that.

Mr. McDERMOTT. Mr. Ford will inquire.

Mr. FORD. Thank you very much, Mr. Chairman.

Let me raise just one or two questions to members of this panel. Yesterday, as we know, representatives of some of the Nation's largest employers came out in strong support of an alternative plan of the administration's.

As we know, we have seen several provisions within the Clinton's bill, one being the cap and the other being the assumption by the Federal Government of health care costs of early retirees that are beneficial to the business community. I recognize that some members of the business community may support access and others support universal coverage, while some oppose mandates. I am sure that many of you and other large employers are split on some of these provisions in the administration bill. Nevertheless, the business community supports provisions that help business. In light of that, how do you respond to business community representatives who have embraced an alternative plan instead of a plan with provisions which they favor?

Mr. BRENNAN. Are you asking if—

Mr. FORD. Should we not try to come up with some means to support the administration's proposal rather than taking an alternative plan and making that the centerpiece of a health care reform package?

Mr. BRENNAN. If I could respond. Certainly the Cooper bill is appealing to our industry and our company. We have spent time meeting with Mr. Cooper and trying to understand his plan.

Having said that, I am here today representing our organization to communicate our concerns, and to express the hope that we can work something out through the legislative process. We have looked at every plan out there. We have looked at the Clinton plan. I gave you my views on that plan earlier. Certainly the Cooper plan is attractive to our organization, but our purpose is to look for a way to move an acceptable plan through the proper legislative process.

Mr. FORD. What about those provisions within the Cooper plan that are not attractive to the larger employers of this country?

Mr. BRENNAN. Certainly the early retirement question is a major issue for us.

Mr. FORD. As the early retirement provision is within the administration's proposal?

Mr. BRENNAN. That is right.

Mr. FORD. What other provisions in the administration proposal do you see in the alternative plan, the Cooper plan?

Mr. BRENNAN. I think when you compare the Cooper plan across the board with the other plans, it appears to be very similar. It offers access. It eliminates employer mandates. Apart from that, you see a great many similarities. That is my point of view.

Mr. FORD. What about the Medicare and Medicaid long-term care provisions? The larger employers naturally are trying to protect their business interests, and rightfully so. However, if we are talking about a comprehensive plan with not only universal access to preventive and primary care, but having universal coverage that many of my colleagues have talked about today with this particular panel, do you think there are similarities between the the administration plan and the Cooper plan?

Mr. BRENNAN. I think there are many similarities. I asked Congressman Cooper about the issue of Medicare. I don't fully understand it at this point, and I would like to have more information about it.

Mr. FORD. Is that something that the larger employers will intend to do, directly addressing provisions rather than saying there are a lot of similarities across the board.

Mr. BRENNAN. We will look at every provision in Mr. Cooper's bill, and all other bills, just as we have with the administration's bill.

Mr. FORD. Will you share that information with members of this committee and other Members of Congress—

Mr. BRENNAN. We'll be happy to do that.

Mr. FORD [continuing]. So we can move along in this health care debate?

Mr. BRENNAN. I'd be happy to be invited back to talk about it.

Mr. FORD. Are there others who would like to comment?

Mr. PATRICELLI. Mr. Ford, the Chamber has endorsed no bills as yet.

Mr. FORD. No, I was not implying that the Chamber endorsed a bill, but I was talking about those representatives of some of the Nation's larger employers. I know that the Chamber has not. You may proceed, I am sorry.

Mr. PATRICELLI. Well, we have not taken the position that the Business Roundtable has, in terms of saying that the Cooper bill is an appropriate starting point. We do have some concerns with the Cooper bill that have to do with the structure of the tax cap and have to do with the nature of the mandatory alliance provisions, in particular, but then we have some difficulties with other bills as well.

We have been reluctantly forced to conclude, however, that of the principal proposals that have been offered, the President's is, unfortunately, the least attractive because it is so burdensome in terms of regulation, price controls and costs that we do not think it is an appropriate starting point.

Mr. FORD. We have restructured our Medicaid program in the State of Tennessee. It is called TennCare. My colleague and good friend, Representative Cooper, has strongly opposed TennCare. TennCare was implemented on January 1, and there are a lot of problems within many of its provisions. As I look at the Cooper plan, I see a lot of similarities with TennCare, although Representative Cooper is in opposition to TennCare.

I am concerned. There are certain elements in the Cooper bill that I can support. I would like to see us continue to debate the bill and see how we can come up with a universal health care plan,

but one that not only gives access to preventive and primary care, but also gives universal coverage for everyone. Thank you.

Mr. McDERMOTT. Mr. Herger will inquire.

Mr. HERGER. Thank you very much, Mr. Chairman.

Mr. Patricelli, you represent the U.S. Chamber of Commerce.

Mr. PATRICELLI. That is right, sir.

Mr. HERGER. Just a general question. Did you feel that the President's Health Security Act would impact differently large businesses than smaller businesses?

Mr. PATRICELLI. Yes, very clearly so.

Mr. HERGER. And I am very pleased with what I have heard you say today. Evidently, as you mentioned earlier, it is not over until the fat lady sings, and I believe your quote was, you are the fat lady. And even though we had had some indication earlier that perhaps the Chamber of Commerce was coming out in favor of mandates, my understanding is that you are not now; is that correct?

Mr. PATRICELLI. To be——

Mr. HERGER. Employer mandates, that is.

Mr. PATRICELLI. To be as clear as I can on that subject, we have not ruled them out. We do not think, as a matter of responsible policy considerations, you can rule them out. However, we have seen no proposal involving a mandate that would be remotely acceptable because of the cost, regulation and price controls that seem to be involved in most of those.

We have come a little closer with some elements of an individual mandate, but even that has some significant concerns, and, as has been said earlier, you cannot take the mandate issue out of the context of the whole package.

Mr. HERGER. I think a statement that evidently you had clarified—I am just looking at a report in today's Wall Street Journal, which, evidently, in your original testimony before this committee, I believe you said the Chamber could accept the proposition that your employers should help pay for insurance on a phased-in basis. Again, this would appear, as you mentioned, you are leaving it open.

You mentioned earlier to me that you do see a difference, in effect, between large businesses, multimillion dollar businesses, and the type of businesses that most of us represent—certainly I do in rural northern California—which are virtually exclusively all small, as are most businesses. In what way do you see it affecting them differently?

Mr. PATRICELLI. In two principal ways: One, simply in terms of cost; and the other is in terms of how they would access the insurance market.

On the former, of course, the concept of an employer mandate is going to fall most expensively and heavily on businesses that do not currently provide insurance, and those are predominantly small businesses, under 25 employees in size, with low-wage employees. And so unless there is some major government subsidy, those folks are going to pay a very grave, important, additional burden that they may not be able to sustain. And, of course, if you can bring in a subsidy, as the President has, you have to look at whether you are creating an entitlement that over time you can sustain.

Larger businesses, by and large, are already providing benefits; although interestingly not at as high a level on the average as the President's program would set up.

The second issue, aside from cost, sir, is the fact that smaller businesses really are forced to go through a community-rated mechanism and to buy through these new and untested regional alliances. And even if the cap for this alliance structure comes down, it does not seem to us to be appropriate to have mandatory monopolistic quasi public utilities through which you have to get your insurance.

Larger businesses traditionally have been self-insured. They have been managing their own costs, increasingly more effectively, but, unfortunately, the Clinton bill would put an end to most of that as well.

Mr. HERGER. Again, I appreciate your comments, because what you are saying is what I hear as I talk to literally hundreds of small businesses around my district. Those who have either just started or those that are the ma and pa type of business, which is just barely getting by, this type of mandate—virtually all my restaurants in my districts have the same type of concern of this type of mandate; that basically it would completely put these people out of business. Not only would their employees not have health care but they would all be on unemployment insurance.

And just to finish up, I guess the big concern I have and the big concern I have had with the Chamber of Commerce over this last year is that it would appear that we are pitting the big businesses, the ones that have the big pocketbooks out really, against small business, which is over 80 percent of all businesses, putting them at a severe disadvantage. And I am happy to see that again you, representing big business, is changing that somewhat and would look at the betterment of the whole country and the betterment of all business rather than just that of big business. So thank you very much.

Mr. McDERMOTT [presiding]. The gentleman from Louisiana, Mr. McCrery, will inquire.

Mr. McCRERY. Ms. Connerton and gentlemen, I applaud your stamina, and—

Mr. McDERMOTT. OSHA requires work breaks after 3½ hours. They have been there a long time.

Mr. McCRERY. I understand, and I applaud their stamina. In the interest of time, Mr. Chairman, I will simply associate myself with the remarks of Mr. Santorum and Mr. Bunning and the opening line of questioning with Mr. Archer with respect to medical savings accounts and the third-party payment system; and for emphasis, I would simply add, if we don't do anything to reduce the influence of the third-party payment on the health care system—and that is to say, give individuals more of an economic interest in controlling the cost of the system—you are whistling Dixie.

And the only way you are going to control costs without reducing the influence of the third-party payment system, is to bureaucratically ration care, which is what they do in all the countries that Mr. Chairman spoke so favorably of earlier today.

Mr. McDERMOTT. Are you starting something?

Mr. Hancock, you will inquire.

Mr. HANCOCK. Just a real quick question, I'd like to just ask the panel if you are willing to volunteer the information. How confident are you that the 7.9 percent ceiling that they are talking about now, the President's talking about and everybody else is talking about—how confident are you that that 7.9 percent of payroll will last very long, to take care of all of our hospitalization and medical care needs for the entire country?

Mr. PINKUS. I think I stated earlier, we have zero confidence. And I think just about every kind of plan that, you know, where costs have been estimated by economists and the Congressional Budget Office and so on, have been way below the mark as to what actually happened. And we—nobody has any—when I go out on the street and talk to my members in Texas, I can't find who thinks—I mean, they laugh, when they see the 7.9 percent cap.

Mr. HANCOCK. Does anyone else want to comment?

Mr. DUNTON. It is quite easy for people that don't provide any coverage at all to say that the 7.9 percent won't get it. Everything I read in the Washington Post indicates that every year we add a few more million people with no coverage, and the longer we do that, the longer those that are continuing to provide coverage—it just escalates and shuts those facilities down.

And so we are chasing our tail with this process.

Mr. BRENNAN. I don't think that we even have to look at the economists' projections. We only have to look at the empirical evidence in regard to Medicare as a good example of what can happen.

Mr. HANCOCK. Why don't we go back a little further than that? I have got a copy of the original handout piece they use for Social Security, and it says, beginning in 1949, 12 years from now, you and your employer will each pay 3 cents on each dollar you earn up to \$3,000 a year. This is the most you will ever pay.

I think the empirical evidence is pretty evident. In fact, I don't know that I have ever heard of a government program that really came in under—a continuing program that didn't cost more than it was projected. In fact, recently somebody told me—it was a businessman—I have never seen a pro forma study that I didn't like. And there is a lot of logic to that.

Mr. THOMAS. Will the gentleman yield briefly?

Mr. HANCOCK. Certainly.

Mr. THOMAS. Thanks. I think we are all laboring under the problem, as we attempt to try to determine costs for projection, we all have to understand that the Congressional Budget Office hasn't given us the estimates on the President's program.

I applaud these folks who aren't willing to enter into negotiations on how much they are willing to pay when they don't know what the price tag is. So the gentleman from Missouri is absolutely correct. We don't even know what CBO is going to tell us yet about what the actual costs are. And I look forward to those as soon as we are going to be able to get them, because at least we can then argue over the numbers, as to whether they are realistic or not. Right now we don't even have any numbers.

I thank the gentleman.

Mr. McDERMOTT. Tuesday we will know.

Mr. Hancock.

Mr. HANCOCK. I would also like to make a comment as a small employer before I came into the Congress. I can't be active in my business but under the ethics rules up here, I can look after my own personal financial affairs—my employees have opted for a very broad retirement plan, completely paid for by the company. We pay for it. And that has been their decision.

Here again, won't mandated provisions—that will mean that my employees will no longer be able to decide whether they want company-paid insurance or whether they want a very broad pension plan. Isn't that a little bit of an infringement on the rights of the individual? It would appear to me that the mandate should be on the individual.

Now I know that the reason that we can't mandate it on the individual is because the voters are going to raise old Billy Cain when you mandate it on them, that we have to buy, that they have to pay for insurance whether they want to or not. But let's mandate it on the businessman, let's mandate it on the employer. Then let's let the prices go up on his goods and services, and it ends up all coming back on the employee anyway.

I mean, the business community is—I mean, that isn't going to come out of thin air unless the Federal Government can print dollars.

Mr. BRENNAN. As I said earlier, I agree with you. Prices can only rise so much. The issue is jobs, the issue is the economy, ultimately.

Mr. HANCOCK. There is an issue of freedom here, too. If the individual says, I will take care of my own medical care, I don't want the government telling me what I have got to do—I mean, there is such a thing as basic freedoms under the Constitution.

Ms. CONNERTON. Well, let me just say, there is the issue of basic freedoms in the Constitution. But there are a lot of folks today who—particularly younger, healthy people, who opt to go uncovered. But assuming that they were to get sick, we don't let them die in the hospital; we treat them and somebody has to foot the bill.

I think there is a question of responsibility, and I think that it is a shared responsibility.

I think employers, for the reasons that you say, have a very important role to play in this, and it is different from certain other kinds of activities, because we all end up paying for the uninsured.

Mr. MCDERMOTT. We want to thank the panel. You have been sitting there for almost 3 hours. But that is a tour de force, and we appreciate your testimony before the committee. Thank you very much.

Mr. MCDERMOTT. The next panel will be John Motley, vice president for Government relations for the National Federation of Independent Businesses; Charles Butson, National Grocers Association; John Woodhouse of the National-American Wholesale Grocers Association; Michael Resnick with the National School Boards Association; and Kenneth Melley of the National Education Association.

In an effort to return to a level of fairness, I will be firm on the 5-minute rule. Otherwise, we are going to be here at midnight. We have got a long day.

Everyone's statements will be put in full in the record, and if you would summarize your testimony or add additional things, we would appreciate that. And we will begin with Mr. Motley.

**STATEMENT OF JOHN J. MOTLEY III, VICE PRESIDENT
FOR FEDERAL GOVERNMENTAL RELATIONS, NATIONAL
FEDERATION OF INDEPENDENT BUSINESS**

Mr. MOTLEY. Thank you, Mr. Chairman. Good afternoon. On behalf of NFIB and its more than 600,000 members across the country, I want to thank the committee for the opportunity to appear and testify here today. Over the last 4 to 5 years, I think that I have testified almost a dozen times before this committee on health care reform. And in favor of health care reform. It has been a major problem for America's small business community.

Unfortunately, in appearing here today, I must oppose the administration's proposal, primarily because of the requirement on employers to pay for 80 percent of the health care costs for all of their current and future employees and their families.

In our opinion, the administration's proposal does one thing. It trades jobs on Main Street for health care reform, and we believe that is a very poor trade, especially for the employees of small business owners in this country.

Over the last 18 months, we have polled the issue of employer mandates and most recently the mandate in the President's proposal—the most recent poll, the last two polls done by Gallup—and well over 80 percent of our members responding to those polls are opposed to the President's suggested solution.

When I appeared last August in Tulsa before the National Governors' Association, it was my intention then to talk about some of the myths that revolved around the small business community and health care coverage; and in fact, to try and debunk some of those myths in the interest of shedding some light on the debate that was going on. Unfortunately, most of those myths have persisted and, in fact, others have arisen. And today, I would in my remarks like to discuss two of them that I think are critical to understanding the very strong opposition of the small business community to the administration's proposal.

First of all, it has become very popular for spokespeople within the administration to say that, "The majority of small business owners will pay less into the President's program." Mr. Chairman, that is mathematically impossible, and therefore it is untrue. It is mathematically impossible because we only have 5 million employers in the United States. That is a Department of the Census figure.

Of those 5 million, 60 percent have 4 or fewer employees. And 74 percent of those, according to the Health Insurance Association of America and very closely to other organizations, or 2.2 million of them, do not provide health insurance for their employees.

Now, the recent Lewin-VHI study which the administration has embraced says that 50 percent of those employers that do provide health insurance are also going to see cost increases under the President's program. So if you take the 50 percent of what is remaining, which is 2.8 million firms, you come up with 1.4 million, and you add that to the 2.2 and you get 3.6; and my calculations,

as bad in math as I am, is that is 72 percent of the businesses, the small businesses in this country, are going to experience a cost increase under the President's proposal.

I might also add that Lewin mentioned that for firms from 1 to 25 employees in the first year of the President's proposal, the cost increase will be \$25.2 billion, while there will be a cost decrease—a cost decrease for firms over 100 employees. It seems to me that something is definitely, definitely out of whack in that type of a plan.

The second myth I would like—or misconception that I would like to address, and that is also very widely accepted, is that there is a 7.9 percent payroll cap in this plan.

Mr. Chairman, according to our reading of the bill, and frankly, according to the committee's reading of the bill, there is no payroll cap. Let me quote from a December 21, 1993, Ways and Means Committee press release:

"The premiums paid by employers would include additional assessments to cover the costs of certain federally financed programs such as academic health centers and graduate medical education and allowance for—and alliance administrative costs and collection shortfalls," which basically means that there are a whole series of reasons why the alliances can abrogate the 7.9 percent supposed cap which is in the bill.

In addition, the subsidies and the caps which are talked about are subject to the will of the budget and subject to the will of this Congress, and frankly, like Senator Moynihan and like Congressman Waxman, we question whether the money will be there to finance these subsidies and caps in the future.

Now, the proposed mandate has immense consequences for the small business community in our opinion. Number one, it locks them in and it makes them responsible—remember, there are no changes once it is in place—makes them responsible for funding 80 percent of an untried, unproven, untested program for all their current employees, their families, and for all future employees and families. Now stop and think about that for 1 second.

After what we have experienced in the last two decades in health care costs and our ability to control health care costs in this country, wouldn't that be frightening if you were a small business owner, that you were going to be locked into a system that you had absolutely nothing to say about, when the current system is driving you, in some cases, to bankruptcy?

What the mandate means for the small business owners and for the American people, we believe, is that payroll costs will rise—they have to; businesses will close—only a few, but some will close; employees will lose their jobs; and others will have their pay cut, or they won't have pay increases in the future, because employers will have to find some way to offset the costs.

In the Gallup Poll that I mentioned before, even at 3.5 percent of payroll, 31 percent of our members said that they would let employees go at 3.5 percent of payroll.

And last, and I think most ominous probably for this committee and for public policy in this country, is that I believe that we are going to have fewer new businesses started because you have raised the threshold higher in terms of payroll taxes, which have

no relationship to the profitability of the firm. Therefore, we are going to have fewer new jobs. And we have gotten an awful lot of the new jobs in this country from the small business start-up cycle.

In conclusion, Mr. Chairman, NFIB has worked with many members of this committee on health care reform in the past. We support the legislation introduced by Congressman Andrews and the legislation introduced by Congressman Thomas, and we worked with others of you on legislation that has been introduced. We oppose the administration's proposal because we believe it is going to have an impact upon small business owners and small business jobs, and therefore, small business employees. As we see it, the hammer from the Health Security Act is going to fall hardest on America's main streets.

Thank you, Mr. Chairman.

Mr. McDERMOTT. Thank you.

[The prepared statement follows:]

STATEMENT OF

JOHN J. MOTLEY III
VICE PRESIDENT, FEDERAL GOVERNMENTAL RELATIONS
NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Good morning. My name is John Motley and I am Vice President for Federal Governmental Relations for the National Federation of Independent Business (NFIB). NFIB is the nation's largest small business advocacy organization, representing more than 600,000 small business owners in all fifty states. The typical NFIB member has five to eight employees and grosses \$250,000 in annual sales. NFIB sets its legislative positions and priorities based upon regular surveys of its membership.

I want to thank you, Mr. Chairman, for inviting NFIB to testify before this committee. I want to commend you for dedicating this entire hearing to the provisions in the Health Security Act (HSA) that would require employers to pay for 80% of a comprehensive health benefits package for all employees. No issue Congress will consider for years to come will have a greater impact on Main Street small businesses and the people they employ than the health insurance employer mandate. No issue has a greater capacity to challenge and possibly reverse what NFIB sees as the emerging consensus in Washington and around the country about how to reform health care in America and how small business should be treated in that reform effort.

Two Key Questions

Few public policy debates in the nation's history have been more complex than the national debate now taking place over health care reform. But the debate over the employer mandate can quickly be distilled down to two basic questions:

(1) What impact would the employer mandate in the Health Security Act have on small businesses and the people employed by them?

(2) How would the proposed small business subsidies and payroll caps in the Health Security Act alter that impact?

Based upon nearly a decade of research and surveys about small business and health insurance along with careful study of the Health Security Act, my testimony will attempt to answer each of these questions. First, it is important to provide some context about the conditions in which small business owners currently find themselves when it comes to purchasing health insurance for their employees.

Health Care Reform for Small Business: Dr. Jekyll and Mr. Hyde

Whether you call it a crisis or a problem, small business owners are clearly the victims of the many flaws in the current health insurance market. They often pay approximately 30% more than larger companies for similar benefits because of administrative costs. They often pay an additional 30% more in premiums because of costly state mandates for specific types of insurance coverage, which prevent small business owners from shopping for only the basic care that their employees might need. Larger firms that self insure, by contrast, are not subject to these costly mandates. In addition, a small firm is far more likely than others to feel the painful brunt - both economic and emotional - of the preexisting condition exclusion or, when an employee gets sick, the 20% to 300% premium hike or the sudden cancellation of insurance. Insurance companies are much more likely to require exclusions, raise premiums or cancel policies to shield themselves from risk when insuring a small firm rather than a large business.

Small business owners who provide insurance for their employees or who are attempting to are currently stuck in this dismal situation just described. They have nowhere else to go. Their firms are usually not large enough to self insure and they often do not have access to managed care arrangements. In NFIB surveys, small business owners have said that health insurance is a benefit they want to offer - it gives them a competitive advantage in a labor intensive sector of the economy - but they often find its cost prohibitive or they can't find it at all.

All of this accounts for a trend in NFIB Foundation surveys that began in 1986. In that year, small business owners for the first time identified the cost of health insurance as their number one problem. That trend has continued ever since, with the cost of health insurance proving to be twice as critical a problem as the number two problem in the survey, federal taxes on business income.

For all of these reasons, health care reform has, over the last decade, become NFIB's most important legislative priority. We have said for many years that the status quo in health care is unacceptable. But NFIB and the small business community are also keenly aware that health insurance reform has a "Dr. Jekyll and Mr. Hyde" character about it. Either small business owners will be able to continue to thrive and produce the majority of new jobs in this country through meaningful reform or they will be required to pay substantial new costs that many of the smallest firms cannot afford. Unfortunately, the employer mandate in the Health Security Act falls into the latter category. It will result in job loss in the smallest, newest, most marginal firms in the economy. The explanation of why this will occur can be found in the answers to the two questions previously posed.

1. What impact would the employer mandate in the Health Security Act have on small business?

The Impact of Payroll Taxes

Title I of the Health Security Act would enact into law the idea that all Americans are entitled to a comprehensive set of health benefits which President Clinton has said is akin to that offered by Fortune 500 companies. Title I also places into law the requirement that all firms must pay for 80% of this Fortune 500 package for all employees, including Medicare recipients, and pro-rated payments for part-time and seasonal workers.

Title VI of the bill stipulates that almost all employers must fulfill this obligation by paying a specific percentage of payroll to a Regional Health Alliance. These mandatory payroll

based premiums are a huge, new payroll tax levied to pay for 60% of the proposed new health care system.

Small business owners know this is a tax increase. They know that the mandate would fund an entitlement created, managed, and regulated by the federal government, no different from Social Security, Medicare, Medicaid, or unemployment insurance. They know they would have to pay a percentage of payroll for this entitlement and withhold a portion of their employees' wages for the program, just like other government programs. They know that any effort they undertake to provide health insurance differently, less expensively, or perhaps not at all would be met by audits and penalties, both civil and criminal.

Whether or not to call these mandatory payroll premiums a tax is not a difficult decision. It may be a political decision, but it is not difficult. Ask any small business owner in America whether or not this is a payroll tax. Not a one of them will have to defer to the director of the Congressional Budget Office for the answer. They know it is a payroll tax. And they would be shocked to learn that the largest employer funded government entitlement in history could be invisible in the budget books of the federal government.

The question of whether the employer mandate is a payroll tax or a premium is not merely a game of words, nor is it just a question of precedents in federal budget practices. It is important because it clearly shows that the employer mandate in the Health Security Act, regardless of its official label, has every characteristic of the kind of mandatory payment that is most damaging to a small firm and the jobs it creates: it is a payroll tax.

Payroll taxes must be paid regardless of the financial health of a business. For small businesses, most of which survive not on profitability but cash flow, this is a particularly dangerous threat. This problem is acute in new businesses, which create one in three new jobs in the U.S., because a new payroll tax is an additional fixed cost on those businesses every time they want to grow and hire new employees. Payroll taxes assessed to pay for mandatory benefits give small business owners a new cost over which they have no control, limiting their ability to provide the best possible compensation package for each individual firm's survival and employees. And because most small firms are labor intensive, particularly in the retail and service sector, small firms take a disproportionate hit from a payroll based tax. Such taxes create incentives for buying machines and paying overtime (instead of hiring new employees) and disincentives for keeping existing employees. This is exactly the small business atmosphere the Clinton plan's employer mandate would create.

Debunking A Misperception

Some have argued that, despite the damaging nature of payroll based taxes, the employer mandate in the Health Security Act will not hurt small firms because, as President Clinton said during his state of the Union Address, most small businesses provide health insurance for their employees already. This is simply not true. This lingering misperception skews the health care debate and created additional fallacies about how many firms would see their costs go up under the Clinton plan. Because the Health Security Act imposes at least a 3.5% payroll cost increase to all firms that do not currently provide insurance, understanding the demographics of the employer community and what firms do or do not provide health insurance is crucial to this debate.

Based on data from the Census Bureau, the Congressional Budget Office, the U.S. Small Business Administration, the Health Insurance Association of America (HIAA), and others, between 40 and 45 percent of employers provide some level of health insurance coverage today. How is it possible that a substantial majority of Americans obtain health insurance through the workplace yet a minority of employers provide insurance for their employees? The answer to this question can be found by walking down Main Street in most congressional districts in this country. Sixty percent of employers in the United States have fewer than five employees. That accounts for three million of our employers. In this group, 74% do not provide health insurance for their employees. NFIB surveys indicate that in most cases, as alluded to earlier, the sole determinant for not doing so is cost. Coincidentally, these are the people getting the worst deal in the insurance market.

Percent of Firms that Do and Do Not Offer Health Insurance (HIAA, 1989)

<u>Firm Size</u>	<u>Offer</u>	<u>Do Not Offer</u>
fewer than 5 employees	26%	74%
5-9 employees	54%	46%
10-24 employees	72%	28%
25-49 employees	90%	10%
50-99 employees	97%	3%
100 or more employees	99%	1%
Total	42% *	58%

* A 1992 HIAA study adjusted this figure to 40%.

The employer mandate precludes a health reform approach that makes it possible for these firms to respond to a reformed health insurance market. Instead, it immediately and disproportionately raises the payroll costs of these firms by 3.5% to 7.9% of payroll and ultimately, makes them responsible for 80% of a very rich standard benefits package.

While small business in general would be hit hard by the employer mandate, minority and women owned small businesses will be hit even harder. These firms tend to be the smallest of our businesses. Minority owned businesses represent approximately 10% of all businesses, but only account for 3.9% of business receipts. In addition, of those minority owned firms that have employees, the average number of employees is 3.1. Women owned firms tend to be in the retail and service sector, which often tend to be small businesses.

Lewin-VHI, the health care consulting firm whose report on the Health Security Act the Clinton Administration embraced, has estimated that employers that do not currently provide health insurance for their employees would have \$29.3 billion in increased payroll costs in the first year the law would be fully in effect. Between 1994 and the year 2000, firms that do not now provide insurance would have \$107 billion in new payroll costs. These figures take into account a small business subsidy. Because of the demographics mentioned earlier, the smallest firms in the economy would bear a disproportionate share of this cost.

What would these firms with fewer than five employees do? How will they react to a new payroll tax? One option is to raise prices. But a small firm in an extremely price sensitive market could lose a significant customer base and might consider that committing suicide, and would choose to avoid that option. Another option is to reduce employee wages to cover the new payroll cost, but this cannot be done if the worker is earning the minimum wage. A third

option is to let one or more employees go and limit hiring to the greatest extent possible. NFIB believes that the third option is the most likely to occur. In a September Gallup survey done for NFIB, 31% of small business owners said they would have to reduce the number of employees in their firm with even a 3.5% increase in payroll costs. Low wage workers, for reasons mentioned here, will be the first to go, severing the first step on the economic ladder for the working poor.

What about firms that do currently insure? The Lewin-VHI study estimates that nearly half of them would pay more for health insurance under the Clinton plan. The study says that firms that do currently provide insurance will net \$400 million in savings by 1998. But this figure relies on \$42 billion in savings from two forms of government intervention and spending that we believe are not likely to last over time given political pressures and financial constraints: premium caps and payroll caps. This means that most firms that would save money under the Clinton plan would be relying on a government subsidy or price controls, items over which they would have no control, to keep their costs down.

If a small firm already provides insurance for its employees, what would explain its health care costs rising under an employer mandate? Under the Clinton plan, a restaurant that provides health insurance for its full time cooks and managers but not its high turnover part time staff would likely spend more on health insurance. A contractor who provides health benefits for his secretary and his one full time worker but hires additional employees for the summer months would likely spend more on health insurance. A growing computer firm that provides insurance for employees, has an average wage of over \$24,000, but has managed to keep its health care costs low through a basic benefits package and high employee cost sharing would likely see its health insurance costs go up.

Whether a small firm provides health insurance or not, there are certain concerns about the employer mandate that they will undoubtedly have in common. One is the wave of paperwork that employers would have to submit to Regional Alliances to prove compliance with the law and calculate payments, which would be a hidden payroll tax on employers. Second, employers are deeply concerned about a standard benefits package that sets Fortune 500 coverage as the minimum standard for health insurance. The Lewin study estimates that the annual per employee cost of the comprehensive benefits package in the Health Security Act would be between \$5,000 and \$6,000, 18% higher than Administration estimates.

Growing Agreement on the Employer Mandate

All of the problems cited in this testimony regarding the employer mandate contribute to the near unanimity among the American people, congressional leaders, economists, and even proponents of the mandate in the White House that it would result in job loss and prove damaging to small business:

- * **Public Opinion.** 64% of Americans are concerned that the Health Security Act will cause employers to eliminate jobs, and 73% of Americans believe the plan would hurt small business. (Washington Post, 10/12/93)
- * **Congress.** Congressional leaders in both parties have expressed deep reservations about the impact the mandate would have on small firms. Typical of such sentiment are the comments of Senate Small Business Committee Chairman Dale Bumpers who said on December 9th of last year: "There are literally hundreds of thousands of small business people in this country that might have to close their doors under the President's [health care] proposal. That is unacceptable."
Mr. Chairman, you expressed similar sentiments last September, remarking that the mandate will "adversely affect the small businessman."
- * **The White House.** The Council of Economic Advisors acknowledged that 600,000 jobs could be lost under the President's plan. The small business subsidy plan is in and of itself an acknowledgement of the burden that would be placed on small firms by the mandate.
- * **Economists.** A 1000 member survey of the American Economics Association in June 1993 indicated that 80% of the economists interviewed projected a decrease in employment among all employees as the result of requiring employers to provide health benefits to low wage employees.

Another study, conducted by the Employment Policies Institute in September 1993, concluded that requiring employers to pay for worker's health insurance expenses would increase labor costs, leading to the loss of 3.1 million jobs. These job losses would be concentrated in just a few industries. 75% or more would be in restaurants (828,000 lost jobs), other retail trade (726,000 lost jobs) and agriculture (194,000 lost jobs). Other industries that will see disproportionate job loss are construction, repair services, personal services and private household services.

A CONSAD Research Corporation study conducted in May 1993 found that three leading health care reform plans requiring employer mandates could impact 7.5 million to 18 million jobs in terms of reduced wages, reduction of other benefits and potential cuts in hours worked. Job loss estimates ranged from 400,000 to over 1 million.

* **Small business owners.** As mentioned previously, in a survey of NFIB members taken by the Gallup organization last September, 31% of respondents said they would have to lay off workers if they had a 3.5% increase in payroll and 38% said they would have to do so if their payroll costs went up 8%. Eighty-four percent of NFIB members said they opposed the employer mandate in the same survey, and a plurality said their opposition would grow stronger if there were a government subsidy to defray the cost for small, low wage firms.

* **Proof from abroad.** Europe is suffering from double-digit unemployment levels in part due to the fact that some countries have raised the benefits threshold for creating a job to a point where it matches what an employer can expect to pay in straight wages.

Some will argue that this growing consensus on the problems associated with the employer mandate is questionable because it does not take into consideration the small business subsidy included in the Health Security Act. It is a fair question to raise, which leads to the second key question of the employer mandate:

2. How does the proposed small business subsidy and payroll caps alter the impact of the employer mandate?

This question must be considered in two ways: short term and long term. Based upon NFIB's careful analysis, in neither case is the outlook bright. Section 6123 of the bill outlines the small business subsidy scheme through which the required health premium costs for small firms (under 75 employees) would be limited to 3.5% to 7.9% of payroll. The federal government would pick up the rest. While NFIB appreciates this recognition that some small firms simply cannot afford to pay 80% of a government mandated "Fortune 500" health plan, these subsidies and payroll caps have so many weaknesses that small business owners view them as unreliable, undesirable and under-financed.

Short term

In the short term, NFIB estimates that at least two of every three employers in the U.S. will have increased health care costs under the Health Security Act. This figure is based upon the employer demographics and the Lewin-VHI study cited earlier. Again the lion's share of these costs will be borne by the very smallest firms in the economy.

An additional short term problem is that there are already mechanisms in the Clinton plan that would raise an employers costs over and above the 3.5% to 7.9% payroll caps that the bill guarantees. For example, a December 21, 1993 Ways and Means Committee news release stated, "the premiums paid by employers and individuals would include additional assessments to cover the costs of certain Federally financed programs, such as academic health centers and graduate medical education, alliance administrative costs, and [premium] collection shortfalls (sections 6101, 6107, 6125, 1352, 1353 of the Act)." It is NFIB's view that these additional assessments undermine the payroll caps and could cause health care costs to skyrocket, to the detriment of small firms.

Long term

There are several reasons to believe the small business subsidy is unreliable over the long haul and will be phased out over time:

- (1) The percentages of payroll at which mandated health care costs are capped would always be subject to change. In fact, since the first unveiling of the President's plan, they have changed at least two times.

Example: Mr. Smith owns a landscaping company and employs 26 people who on average make \$15,000 a year. When the first draft of the President's plan was released on September 7th, his health care costs were capped at 3.8% of payroll. But what happened when concerns were raised that the health bill was not paid for? On October 4th, a new subsidy table came out which would have raised Mr. Smith's cap to 4.4% of payroll (BNA's Daily Health Care Report). When the Health Security Act was finally submitted to Congress in November, Mr. Smith's payroll cap rose again to 5.3% of payroll. In these two changes, Mr. Smith's already considerable mandated health care costs rose \$5,850 per year. This process would only be magnified if the employer mandate were law and political and fiscal pressures mounted. Because of financing problems, the payroll caps appear to be made of swiss cheese.

- (2) While the bill "entitles" certain firms to payroll caps based on their size and average wage, it places a cap on the amount of funds that would be available for this entitlement. This means that if estimates for the cost of this entitlement are off, the "caps" of 3.5% to 7.9% are meaningless.

There is every reason to believe that the Administration estimates will be off. Neither the Bureau of Labor Statistics nor the Small Business Administration have current statistics of average wages by firm size, making it very difficult to know how many firms will be eligible for the subsidies. Lewin/VHI's recent financial analysis of the plan found the Administration's cost estimate for the subsidy to be off by \$36 billion. Then there is history. In 1965, Medicare was estimated to cost \$9 billion by 1990. It actually cost \$116 billion. Attempts to project entitlement costs, virtually all analysts agree, are very difficult and almost always off. When cost estimates of the subsidy prove to be low, the payroll caps will once again be undermined.

As Energy and Commerce Health Subcommittee Chairman Henry Waxman said last October, "[The subsidy caps] could mean the money just won't be there for low income people and small businesses."

- (3) The Health Security Act allows the states and the National Health Board or Congress to adjust the already generous standard benefits package. Recent experience has clearly shown that a federal government fiscally restrained by huge deficits is inclined to pass and take credit for benefits for which it does not have to pay. If this should happen with the standard benefits package, the small business subsidy would cover less and the employer mandate would cost more.

In light of all the data on the high cost to small business of the employer mandate and the low reliability of the small business subsidy, it is clear that the mandate is the wrong way to finance health care reform. But some will argue that the mandate is indispensable; that health care reform cannot happen without it. This view is simply not correct. This committee, all of Congress, and the President have an enormous opportunity to remove all barriers to purchasing health insurance and expand health care coverage to those who cannot afford it without an employer mandate. NFIB supports numerous steps that would take us in this direction: voluntary small business purchasing groups, insurance reforms, malpractice reforms, administrative reforms, 100% deductibility of health premiums for the self employed, preempting costly state mandates and providing for a basic package of standard benefits. These steps would

bring health care costs down and make it easier for small business owners to purchase health insurance for their employees. These steps embody the emerging consensus on how to reform America's health care system.

As for bringing the 38 million uninsured Americans into the system, there are other proposals besides the employer mandate in the debate that would subsidize uninsured individuals directly. NFIB has worked with members of this committee on both sides of the aisle, such as Representative Mike Andrews and Representative Bill Thomas, on the alternative proposals they support which would do just that. There are a variety of ways this kind of health care reform could be financed: tying employer deductibility of health benefits to the cost of the standard benefits package, limiting the tax free transfer of health benefits to employees, the individual mandate, and reductions in the rate of growth in Medicare and Medicaid are among them. I am not here to endorse any single one of these, but to say that they are worthy of your consideration as an alternative to a financing mechanism that would be very damaging to Main Street small businesses, their employees, and the overall national economy: the employer mandate.

NFIB supports numerous health care reform plans offered by members of both political parties that do not include the employer mandate. I am hopeful we can work together to find a solution that does not achieve health security at the expense of job security.

Thank you.

Mr. McDERMOTT. Mr. Butson.

STATEMENT OF CHARLES P. BUTSON, VICE CHAIRMAN, NATIONAL GROCERS ASSOCIATION, AND PRESIDENT AND TREASURER, BUTSON'S SUPERMARKETS, WOODVILLE, N.H.

Mr. BUTSON. Thank you, Mr. Chairman, and members of the committee. My name is Chuck Butson. I am president of Butson's Supermarkets. My family operates six supermarkets in northern New Hampshire and Vermont. I also serve as vice chairman of the National Grocers Association, on behalf of whom I am testifying today.

The National Grocers Association is a national trade association representing the interests of independently owned retailers and wholesale grocers who comprise the independent sector of the grocery industry.

The subject of health care and the pressures that it places on our businesses is not new. As the owners and operators of community businesses, we care about the health and well-being of our employees and consumers. I am here today to oppose the employer mandates to provide and pay for health insurance as required in the Clinton Health Security Act, H.R. 3600.

NGA would strongly urge the Congress to adopt more market-oriented solutions to the health care problems. NGA is reviewing various health care proposals currently before Congress and is moving toward endorsement of a managed competition approach, such as those contained in proposals by Representatives Cooper and Grandy, as well as Representative Thomas.

During the last 2 weeks, the Clinton administration and the Congress have been hearing from mayors and Governors about the hardships placed on cities and States by unfunded mandates. Mr. Chairman and members of the committee, my message today is the same. The Federal Government cannot continue to force mandates on businesses. Mandated health care will be a trade-off for employee jobs and, in many cases, the future of the very businesses themselves.

Mandated membership into a health alliance destroys existing voluntary group purchasing cooperatives and penalizes employers who have invested time, talent and resources into developing effective market-based health care systems. Purchasing cooperatives for small businesses can and do work all over the Nation without mandated membership in new Federal bureaucracies called a "regional alliance." A program that is basically sound should not be destroyed and recreated when a simple adjustment is a better answer.

The grocery industry is a labor-intensive industry that employs almost 2 million people, almost 50 percent of whom may work on a part-time schedule. Mandated coverage for part-time employees, even on a prorated basis such as under H.R. 3600, imposes a significant and inequitable burden on an industry such as the grocery industry that is dependent on part-time help. An employer mandate is not—nothing other than one more tax on the employer.

Each new government mandate takes away from the wages and benefits of existing employees and inhibits the employer's flexibility

to respond to the needs of his employees, his business, his ability to expand and create new jobs.

In conclusion, NGA urges Members of Congress to support enactment of market-oriented health care reform, which is based upon the concept of managed competition and cost containment and includes the following elements: universal access to health insurance coverage, voluntary small market health insurance purchasing co-operatives, tax incentives to purchase health care, and medical liability reform.

NGA strongly believes that effective health care reform can be accomplished without employer mandate, including mandatory premium payments, excise taxes, payroll taxes or alliance membership, global budgets or price controls.

Thank you very much, sir.

Mr. McDERMOTT. Thank you very much.

[The prepared statement follows:]

TESTIMONY OF
THE NATIONAL GROCERS ASSOCIATION
PRESENTED BY
CHARLES P.. BUTSON

HOUSE WAYS AND MEANS COMMITTEE
UNITED STATES HOUSE OF REPRESENTATIVES
February 3, 1994

Mr. Chairman and members of the committee, my name is Charles P. Butson, President and Treasurer of Butson's Supermarkets, a company consisting of six supermarkets operating in New Hampshire and Vermont. I also serve as Vice Chairman of the National Grocers Association on behalf of whom I am testifying today.

The National Grocers Association is a national trade association representing the interests of independently owned retail and wholesale grocers who comprise the independent sector of the grocery industry. The N.G.A. membership represents the owners and operators of more than 50,000 stores, including supermarkets, convenience stores, warehouse stores and super stores. This sector of the grocery industry accounts for almost half of the \$382 billion dollars in grocery industry sales in the United States.

N.G.A. BACKGROUND AND ANALYSIS

The subject of health care and the pressures that it places on our businesses in the grocery industry are not new. As the owners and operators of community businesses, we care about the health and well-being of our employees and consumers. Health care coverage has been a key employee benefit that promotes employee security and company loyalty. In recent years, the inflationary costs of health care have forced individuals, businesses and government to take steps to manage and control the health care programs offered to employees.

At N.G.A., the evaluation of health care services for the grocery industry has been ongoing for four years. In 1990, N.G.A.'s Public Policy Advisory Council, under the chairmanship of Stephen B. Barlow, President of Miracle Mart, Inc. in Minot, North Dakota, initiated an analysis of the health care problems facing the industry. Members of the council from every state participated in the study. Many provided their insights from both the grocery and health care industries, serving on their local hospital boards and other charitable health care organizations.

In June 1992, the N.G.A. Public Policy Advisory Council issued its report to the industry and the public entitled, "Food for

Thoughtful Debate on National Health Care Reform." A copy has been submitted for the record today.

The principles expressed in the report are still applicable today:

1. While access to basic medical care services should be a fundamental right for all American citizens, it carries with it responsibilities to be shared by the individual, employer, employee and the government.
2. While there is an appropriate role for government involvement in the nation's health care system, provision of medical care must continue to rest with the free market.
3. N.G.A. strongly believes that our future health care system must operate with maximal efficiency achieved through effective cost containment by reduction of fraud, administrative bureaucracy malpractice and anti-trust reform.
4. N.G.A. is firmly committed to retaining the existing quality of the nation's health care system.

EMPLOYER MANDATES ARE NOT THE ANSWER.

I am here today to present testimony in opposition to the employer mandate to provide and pay for health insurance, as required in section 6123 of the Clinton Health Security Act, H.R. 3600. The Act would require employers (including self-employed individuals) to make premium payments for qualifying employees either to the regional alliance or, if applicable, a corporate alliance health plan. The amount of the employer premium payment for each qualifying employee would be 80 percent of the weighted average premium for the specific class of enrollment in the alliance.

Based upon the principles that have been expressed by N.G.A.'s members, and board of directors, I would strongly urge the Congress to adopt more market oriented solutions to the health care problems. N.G.A. is reviewing various health care proposals currently before Congress and are moving towards endorsement of managed competition approach such as those contained in legislation introduced by Representatives Cooper and Grandy, as well as Representative Thomas.

During the last two weeks, the Clinton Administration and the Congress have been hearing from mayors and governors from all across the country about the hardships placed on the cities and states by unfunded mandates. Mr. Chairman and members of the committee, my message today is the same - the federal government can not continue to force mandates on businesses. Mandated health care will be a trade-off for employee jobs, and in many cases, the future of the very businesses themselves.

On behalf of the members of the National Grocers Association, I voice the following concerns relative to the employer mandates in the legislation:

Mandated membership into a health alliance, and mandated employer premium payments, discourage all incentive for employer program management, individual responsibility or cost containment. Health care costs are increasing at almost triple the current rate of inflation, rising in 1992 to 14 percent of the Gross Domestic Product, larger than any other civilized nation. Mandating employer membership and premium payment to an alliance removes from the employer any ability or incentive to reduce medical costs through: on site medical care or safety programs, preventative care, comparative insurance price or plan analysis or through a managed employee benefit program. The employer mandate removes from the employer any management responsibility and control of the health care program -- the premium payment becomes simply another unavoidable federal tax. You cannot reduce the cost of the health care system without involvement and interest in the cost/product relationship. With a mandate, the government makes all the decisions - the employer (or the employee) have no vested interest in the product. The result will be continued cost increases.

A mandate for employer paid health care premiums unfairly penalizes small businesses, which are currently less likely to provide health care benefits for employees, and will result in lower wages and cost jobs. Small businesses have been the national engine of growth over the last few years. While large corporations have reduced their workforces in recent years, small business has provided 90 percent of the new job growth. According to a survey by the National Federation of Independent Businesses, 94 percent of the nation's businesses employ less than 50 employees and only 26 percent of the firms with fewer than 5 employees provide health insurance. Even with the government provided subsidies, such that a small business may only pay 3.5 percent of payroll as opposed to 7.9 percent for businesses with more than 75 employees, there are only so many dollars to go around. That mandated 3.5 percent reduces the small employers' flexibility to meet a need that may be more crucial to his employees or, in some cases, to stay solvent and grow.

In addition, the small business subsidy provided in H.R. 3600 provides a built-in incentive to freeze jobs and wages. Employers would attempt to stay at the threshold to retain the built-in small business discount, 3.5 percent of payroll instead of 7.9 percent of payroll. This effect has already been evidenced by several smaller N.G.A. employers who have frozen their payroll below 50 employees to remain under the threshold required to comply with new Family and Medical Leave requirements. Furthermore, one cannot be naive enough to believe that the subsidies will remain at 3.5 percent as the cost of health care premiums outpace the government's ability to continue to provide the small business subsidies.

A nationwide survey by the International Mass Retail Association found that an employer mandate would put 1.9 million jobs at risk. The National Federal of Independent Business estimates that requiring employers to pay for worker's health insurance expenses will increase labor costs leading to the loss of 3.1 million jobs (726,000 of these in the retail trade). The

National Bureau of Economic Research in a recent study concluded that 85 percent of mandated benefits would be paid by workers through reduced wages. Even Laura Tyson, the chairwoman of the President's Council of Economic Advisors, estimates H.R. 3600 could cost as many as 600,000 jobs in its first years.

An employer mandate is nothing other than one-more tax on the employer. Already the employer pays federal and state income taxes, unemployment compensation taxes, federal withholding taxes, Social Security and Medicare payroll taxes and state and local withholding taxes. An employer may pay as much as 10 percent for workers compensation insurance. There are state sales taxes, local property taxes, property taxes for equipment and machinery. If an employer expects to pay a profit, he must prepay estimated taxes. All of these are simply taxes and do not include other costly federally mandated benefits such as family and medical leave programs or voluntary pension, disability or insurance programs. For each \$100 of payroll, the employer is already paying another \$20 in mandated payroll taxes. It is no wonder that the rising cost of employee benefits is ranked by the Grocery Industry Report as one of the grocer's top three operational concerns.

Mandated membership into a health alliance destroys existing voluntary group purchasing cooperatives and penalizes employers who have invested time, talent and resources into developing effective market based health care systems. H.R. 3600 provides that an employer must make premium payments to the regional alliance unless qualified for eligibility, under Section 1311, to belong in a corporate alliance of more than 5000 employees. Purchasing cooperatives for small businesses can and do work all over the nation without mandated membership in a new federal bureaucracy, called the regional alliance. In the state of Minnesota, the Group Health organization was founded by a consumer cooperative in 1939. Purchasing cooperatives flourish all over the state of Minnesota, the result being that Minnesota has one of the lowest per capita health care costs in the country. Group health care purchasing cooperatives and joint ventures have also flourished in the food industry. For many decades, wholesalers have joined together to provide health care benefits for independent, privately owned retail grocers. Two examples are: United Grocers' Health Trust in Portland Oregon, IGA Benefits Trust. The result is significantly reduced health care costs for small businesses and the availability of health care coverage for more employees.

Some of these grocery industry insurance programs and cooperatives will continue to function under H.R. 3600, because they satisfy the membership requirements and definition under the Act. Other food industry programs will not meet that definition and these groups and their members will be faced with mandated membership into a regional alliance and all the disincentives and added costs inherent in the Health Security Act. Purchasing cooperatives or pools work by strengthening the small group market for buyers and sellers and costs will be controlled through those competitive markets --not through government mandates and price controls. A program that is basically sound should not be destroyed and recreated when a simple adjustment is a better answer.

A mandate for employer paid health care premiums discourages part-time employment and penalizes labor intensive industries such as the food industry. The grocery industry is a labor intensive industry that employs almost 2 million people, approximately 50 percent of whom may work on flexible part-time schedules. According to a 1992 Grocery Industry report, the average retail grocery chain store, of 28,000 square feet, employs 33 full-time employees and 60 part-time employees. The average independent retail store, of 16,000 square feet, employs 22 full-time employees and 29 part-time employees. A recent N.G.A. member survey indicated that 96 percent of the respondents provide health care coverage for full-time employees, 45percent of whom provide 100 percent of the cost for employee coverage. Less than 25 percent of those employers provide health care coverage for part-time employees. The overwhelming majority of these part-time employees do not require coverage because they are second wage earners in a family, students or workers holding a supplemental job and are already covered on other family plans.

Mandated coverage for part-time employees, even on a pro-rated basis such as under H.R. 3600, imposes a significant and inequitable burden on an industry such as the grocery industry that is dependent upon part-time help. One North Dakota grocer who currently pays 100percent coverage for his full-time help and 40percent for dependent coverage found that a preliminary calculation of costs using the pro-rated formula under H.R. 3600 for his 88 part-time employees revealed that his cost to cover part-time help alone exceeds his total health care costs for FY 93.

Supermarkets historically operate on a narrow profit margin. A 1992 Grocery Industry Survey by Progressive Grocer magazine reports the average net profit to be 1 percent. In addition, the survey reveals that the top three operating concerns of grocery store owners are: competition, increasing labor costs and the rising costs to provide employee benefits. Mandating additional benefits through an employer paid premium for health care coverage will have three results: reduce jobs particularly for part-time and lower skilled people and decrease flexibility to offer other employee benefits and increase the cost of food to the American consumer.

The grocery industry employer is already drowning in a sea of government overregulation. The Chairman of the DOL's nearly created Commission on Worker-Management Relations, Dr. John Dunlop, noted at his swearing in that in the last two decades the number of federal workplace laws and regulations has grown from 145 to 200, a 33 percent increase. This does not count state and local laws or related laws involving health, tax and social security. In the grocery industry, employers in the last year alone are struggling to comply with the administrative and financial burdens of complying with new requirements under the ADA, the Family Medical Leave Act, the Nutritional Labeling and Education Act and the Clean Air Act which requires retrofitting all refrigeration equipment.

While those who continue to vote for more and more government regulation may believe they do so with the best intentions, in

many instances the logic is more questionable to the small businessman who ultimately must bear the cost of compliance which frequently becomes a full-time job. Each new government mandate takes away from the wages and benefits of existing employees, and inhibits the employers flexibility to respond to the needs of his employees and his business and his ability to expand and to create new jobs. When it comes to an issue of the magnitude of health care reform, we cannot afford to make mistakes.

N.G.A. urges members of Congress to support enactment of market-oriented health care reform which is based upon the concept of managed competition and cost containment and includes the following elements: universal access to health insurance coverage; voluntary small market health insurance purchasing cooperatives; tax incentives to purchase health care; and medical liability reform. N.G.A. strongly believes that effective health care reform can be accomplished without employer mandates including mandatory premium payments, excise taxes, payroll taxes, alliance memberships, global budgets or price controls.

Mr. McDERMOTT. Mr. Woodhouse.

STATEMENT OF JOHN F. WOODHOUSE, VICE CHAIRMAN, NATIONAL-AMERICAN WHOLESALE GROCERS' ASSOCIATION, INTERNATIONAL FOODSERVICE DISTRIBUTORS ASSOCIATION, AND CHAIRMAN OF THE BOARD, AND CHIEF EXECUTIVE OFFICER, SYSCO CORP., HOUSTON, TEX.

Mr. WOODHOUSE. Thank you and good afternoon. I am John Woodhouse, vice chairman of the National-American Wholesale Grocers' Association, and its foodservice partner organization, the International Foodservice Distributors Association, and chief executive officer of Sysco Corp., the Nation's largest foodservice distributor.

I intend to limit my testimony solely to the issue of the employer mandate, although there are several other provisions of H.R. 3600 that trouble us deeply.

As we told this committee in 1991, you do not have to mandate employer-sponsored insurance if you bring down its cost. If Congress had taken the advice of Chairman Rostenkowski and Senator Bentsen 2 years ago and implemented a market-oriented incremental reform package, we might already be well along to solving the coverage problem.

Universal coverage is an appropriate long-term goal, yet the unintended consequences of the proposed mandate will be many and bad. The food distribution industry continues to strongly oppose an employer mandate. We are certain that an employer mandate would have a particularly devastating impact on our industry, driving up the cost of labor and taking away vital flexibility. Clearly, mandating coverage or a payroll tax along the lines of what has been proposed would force employers to eliminate many jobs.

Ours is a very labor-intensive industry and is one in which profit margins are typically very thin. I have yet to discover any secret formula for dealing with such a sudden increase in labor costs. The inability of foodservice companies to absorb these increases ultimately means the elimination of jobs or of some other wage or benefit, or the alternative—extreme price increases. Obviously, neither is good.

On the matter of flexibility, I cannot overstate its importance to the continued viability of this country's economy. A mandate robs a business of its ability to make decisions based on economics. For the same reason that you passed the 1986 Tax Reform Act, you should not impose an employer mandate. Simply put, policies that force businesses to make decisions based on tax avoidance are generally bad.

Our customers, the retail grocery and restaurant business, have for many a generation served as a popular first employment opportunity for ambitious young people. Companies will eliminate part-time jobs when they can no longer afford the costs of part-time employees earning full-time benefits.

I am encouraged at least that you and this committee are holding this hearing today. It is an indication that perhaps we have agreed that an employer mandate is, in fact, a tax. In my view, such an admission is half of the battle in defeating this proposal. I really cannot imagine that a majority in this body would vote to

impose a massive new payroll tax on the fragile economy of our country today.

I would like to reflect with this committee that in 1964, when we decided that no American should be denied access to food, we did not nationalize the food industry, nor did we require that all employers feed their employees or pay a payroll tax. Rather, we developed a very specific target approach which led to the introduction of food stamps and other programs designed to ensure that all Americans had enough to eat. We need a similar approach to this problem now.

To achieve universal coverage on the backs of small businesses and their employees will be a mistake our country cannot afford.

Thank you for inviting me here today, and I will be happy to answer any questions you may have.

Mr. McDERMOTT. Thank you very much.

[The prepared statement follows:]

TESTIMONY OF JOHN F. WOODHOUSE

**VICE CHAIRMAN OF THE BOARD
NATIONAL-AMERICAN WHOLESALE GROCERS' ASSOCIATION/
INTERNATIONAL FOODSERVICE DISTRIBUTORS ASSOCIATION¹**

**CHAIRMAN OF THE BOARD AND CHIEF EXECUTIVE OFFICER
SYSCO CORPORATION²**

BEFORE THE HOUSE COMMITTEE ON WAYS AND MEANS

FEBRUARY 3, 1994

Good morning, Mr. Chairman, Congressman Archer, and members of the Committee. I am John Woodhouse, Vice Chairman of the Board of the National-American Wholesale Grocers' Association, and its foodservice partner organization, the International Foodservice Distributors Association; and Chairman of the Board and Chief Executive Officer of Sysco Corporation. I am very pleased to have the opportunity to appear before you today to discuss an issue which has long been of significance to the food distribution industry -- reform of our nation's health care system.

By way of background, the National-American Wholesale Grocers' Association (NAWGA)--and its foodservice partner organization, the International Foodservice Distributors Association (IFDA)--is an international trade association comprised of food distribution companies which primarily supply and service independent grocers and foodservice operations throughout the U.S. and Canada. NAWGA's 350 members operate over 1200 distribution centers with a combined annual sales volume in excess of \$117 billion. NAWGA members employ a work force of over 350,000; and, in combination with their independently-owned customer firms, they provide employment for several million people. IFDA represents member firms that sell annually over \$30 billion in food and related products to restaurants, hospitals, and other institutional foodservice operations.

Sysco Corporation, listed on the New York Stock Exchange, is the nation's largest foodservice marketing and distribution organization. Operating from distribution facilities nationwide, the company provides its products and services to approximately 245,000 restaurants, hotels, schools, hospitals, and other foodservice establishments. The Sysco distribution network currently covers virtually the entire continental United States and includes all of its 150 largest cities as well as the Pacific Coast region of Canada. Sales achieved during the 53 weeks of fiscal year 1993 crossed the \$10 billion mark to \$10.02 billion -- a growth of 13% over fiscal year 1992. Sysco proudly employs more than 25,000 individuals.

At your request, Mr. Chairman, I intend to limit my testimony to the issue of the employer mandate. I should note, however, that several other provisions of H.R. 3600, the

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Administration's Health Security Act, trouble us deeply. Notably, in addition to the mandate, the provisions related to the establishment of government-run purchasing cooperatives, the price controls, and, generally, the enormous role given to the federal government in the Health Security Act are all proposals to which we are opposed. When we were invited to be here we were in the process of finalizing a comprehensive statement of basic principles of health care reform. I will be pleased to provide that as soon as it is completed.

Mr. Chairman, this is not the first time a representative from the food distribution industry has come before your committee to express our industry's views on health care reform. In October 1991, our association's chairman, Boyd Lee George, appeared before you to deliver what is essentially the same message we have today. NAWGA/IFDA firmly believed then, and continues to believe, that the issues of health insurance coverage and health care costs are inextricably linked. It may sound simplistic, but we still believe that there exists a direct relationship between the cost of health care and the ability of employers to provide coverage for their workers and the dependents of those workers. In fact, our most recent survey on the subject shows that when health insurance costs rose more slowly in 1992 than in previous years, more companies in our industry indicated that they offered employer-sponsored health insurance to their workers.

You do not have to mandate employer-sponsored insurance if you take the steps necessary to bring down the cost of health insurance. Mr. Chairman, if the Congress had taken the advice of you and others two years ago and implemented a market-oriented incremental reform package, we might already be well on our way to solving the coverage problem.

While my company offers a very competitive health care plan to 98% of our workers, many of our small business customers do not. I am certain that if health insurance were more affordable, they, too, would offer it to their employees.

Universal coverage is an appropriate goal. And while we recognize that an incremental reform package might not get us there as quickly as a mandate, the consequences, both intended and unintended, of a mandate are not an appropriate or desirable trade for reaching the goal quickly.

Let me be clear, the food distribution industry continues to strongly oppose any health care reform proposal that contains an employer mandate. The basis of our opposition is both practical and a matter of sound policy. Our opposition is broad and deep, and our commitment to the defeat of any proposal containing a mandate should not be underestimated.

As a matter of policy, we oppose an employer mandate because it takes away from the employer the flexibility he or she needs to make the decisions necessary to keep a company profitable. Furthermore, our experience with the health care systems which are currently under the control of the federal government is not an altogether positive one, to say the least. Why we would want to turn over control of the entire industry or 1/7 of our economy to the federal government's control is beyond me. Like most companies that offer health coverage, we at Sysco have been able to control our own costs through prudent management; and, with all due respect, I simply do not have faith in the federal government's ability to take over that management responsibility on my behalf.

We are certain that an employer mandate would have a particularly devastating effect on the food industry, both retail and institutional. To the point, a mandate would drive up the cost of labor and take away the flexibility necessary to run a business.

As a large company whose customers are nearly all small businesses, Sysco can never disregard the impact of policies on smaller companies. Without customers who are thriving, food distributors simply cease to exist. You have already heard from representatives of small business and the retail grocery industry; and later, you will hear testimony from a restaurateur. I don't know about you, Mr. Chairman, but when my customers tell me that a mandate will close businesses, I get concerned. Furthermore, I have to admit to having the same skepticism about the utility and dependability of the subsidies being considered as an offset.

Any mandate which includes part-time workers, as does the one in H.R. 3600, would have a direct effect on companies, like many in my industry, that have a significant number of part-time workers. Clearly, mandating coverage or a payroll tax along the lines of what has been proposed would force employers to eliminate many of those jobs. These are hard-working men and women whose only mistake will have been being employed part-time when we decided to embark on this flight of fancy called the Health Security Act.

Unfortunately, while the short term impact of a mandate would be the elimination of jobs, the pain it causes does not stop there, as the impact of a mandate in the longer term would be depressed wages. Since more than 90% of our 750,000 potential customers in the U.S. have 50 or fewer employees, many of them part-time, I have a very real and personal concern about the impact of a mandate on the part-time workers of small businesses.

Ours is a labor-intensive industry, and is one in which profit margins typically are very thin. I have yet to discover any secret formula for dealing with increased labor costs. The alternatives are pretty straightforward. The inability of food distribution companies to absorb these increases means that the cost comes out of some other wage or benefit, or prices rise. Neither is a particularly palatable choice.

On the matter of flexibility, Mr. Chairman, I cannot overstate its importance to the continued viability of this nation's economy. On many levels and in many different ways, a mandate robs a business of its ability to make decisions based on economics. For the same reason that you and the other members of this committee passed the 1986 Tax Reform Act, you should oppose an employer mandate. Simply put, policies that minimize the federal government's intrusion into the decision-making of business people are good. Those that force businesses to make decisions based on tax avoidance are bad.

Flexibility in our industry has led to the development of the world's safest, cheapest, most diverse, and most responsive food distribution system. The ability of the industry to respond to the changing demands of consumers can be directly linked to the ability of employers to make economics-based decisions. Do you remember when your local grocery store was only open from nine to five? Flexibility in determining employees' work schedules, delivery schedules, hours of operation, and many other areas would be curtailed by this mandate.

I should note that the demand for part-time work is not only driven by the employer, but by the employees, as well. The retail grocery and restaurant businesses have, for generations, served as a popular first-employment opportunity for ambitious young people. Companies will be forced to eliminate those part-time jobs because they can no longer afford the costs of part-time employees earning full-time benefits.

Finally, it is a reality of life that flexibility is sometimes the only thing standing between the failure and success of a business. Without the ability to react to dramatic changes in the economic environment, many businesses will be forced to close their doors unnecessarily.

I am encouraged, at least, that you and this committee are even holding this hearing today. It is an indication, at least to me, that perhaps we have agreed that an employer mandate is, in fact, a tax. In my view, such an admission is half of the battle in defeating this proposal. I cannot imagine that a majority in this body would vote to impose a massive new payroll tax in this fragile economy.

Although it may not be in vogue to advocate a reform proposal that is not "comprehensive," I cannot help but implore this committee to take a leadership role in advocating a market-oriented reform package aimed at reducing the cost of health care and insurance. A proposal which makes insurance more affordable for businesses and their employees and for self-employed individuals, coupled with a reform of government-sponsored programs for the unemployed would be a significant step forward this year.

I would remind this committee that in 1964, when we decided that no American should be denied access to food, we did not nationalize the food industry. Nor did we require that all employers feed their employees or pay a payroll tax. Rather, we developed a targeted approach which led to the introduction of food stamps and other programs designed to insure that all Americans have enough to eat.

In our quest for the holy grail that is "universal coverage," we should take a lesson from the Crusades in remembering that a noble end does not justify brutish means. Our search should be one that proceeds with deliberation and care. In the end, to have achieved universal coverage on the backs of small businesses and their employees will have been a mistake we cannot afford.

Thank you for inviting me. I look forward to answering your questions.

Mr. McDERMOTT. Mr. Resnick.

STATEMENT OF MICHAEL A. RESNICK, ASSOCIATE EXECUTIVE DIRECTOR, NATIONAL SCHOOL BOARDS ASSOCIATION

Mr. RESNICK. Thank you very much. Good afternoon to the committee. I am Michael Resnick, associate executive director of the National School Boards Association. NSBA represents the 95,000 elected and appointed local school board members who govern the Nation's public schools.

Because school districts employ nearly 5 percent of the Nation's work force, we particularly appreciate this opportunity to testify on the President's health care program.

The Health Security Act creates a difficult but solvable dilemma for school board members. On the one hand, universal coverage will improve the quality of life for millions of American schoolchildren, including the inextricable link between health and educational achievement. However, in paying their share under the Clinton proposal, the school districts are challenged by inadequate revenues, increasing expectations, and the cost of ballooning, unfunded mandates.

A substantial increase in health care costs will deal a devastating blow to many school districts. Even wealthier districts which have strong health care plans express concerns over the increase in cost. Ironically, it will be the poorest districts, those with the most modest plans, that will have the greatest increases.

On the expenditure side, school district budgets may seem large, but \$3 out of every \$4 are spent for employee-related costs. Most of the remainder goes for such fixed costs as debt service and facilities operations. Only 3 to 4 percent of school budgets are available for discretionary spending. Therefore, a substantial increase in health care costs can mean cutting jobs and discontinuing programs and services for children.

On the revenue side, the State and Federal Governments have reduced their proportionate shares in recent years and local taxes cannot cover the difference. In many districts, the unwillingness of local voters to increase property taxes, along with reduced property assessments and tax limitation laws, forecloses that option.

In seeking a solution that produces health reform and excellent education programs, we have five principal recommendations to improve the President's proposal. First, the Clinton proposal would effectively subsidize private employers to the extent their health care costs rise above 7.9 percent of payroll. School districts should have the same protection. The bill currently does not provide that protection.

Second, there is a blanket prohibition against governments, including school districts, from creating their own health alliances, thereby eliminating self-insurance, although that option is available to the private sector. School districts should have the option of self-insurance as well.

Third, if the subsidies and opt-out provisions are available for schools, school districts would look to reducing the employer's responsibility to pay 80 percent of family coverage for full-time employees, and reduce school district costs for adding employees, such as temporary employees or part-time employees—including sub-

stitute teachers who are employed one week and not employed the next week.

Fourth, we would suggest retaining the incentive to reduce Worker's Compensation health and indemnity claims.

Fifth, to reduce administrative costs in the general operation of the program.

In supporting national health care improvements, NSBA looks forward to working with the committee on these five recommendations and other approaches to relieve the local property tax burden, as well as any negative impact on education programming.

Thank you very much, and we would be glad to answer any questions you may have.

Mr. McDERMOTT. Thank you very much.

[The prepared statement follows:]

**STATEMENT OF MICHAEL A. RESNICK
ASSOCIATE EXECUTIVE DIRECTOR
NATIONAL SCHOOL BOARDS ASSOCIATION**

I. INTRODUCTION

I am Michael A. Resnick, Associate Executive Director of the National School Boards Association (NSBA) and a former local school board member in Loudoun County, Virginia. I am pleased to have this opportunity to address the House Ways and Means Committee on the important topic of health-care reform and employer mandates.

The National School Boards Association is the nationwide advocacy organization for public school governance, representing 95,000 elected and appointed local school board members from across the country. These school board members make the key policy and fiscal decisions, including operating an aggregate budget in excess of \$225 billion and employing about 5% of the nation's workforce. The vast majority of school board members are not paid for their service. Rather, they give their time because they care about the education of their own children and the children in their community. The health and education of those children is a very real concern for these community leaders.

II. THE DILEMMA

The Health Security Act creates a difficult dilemma for every school board member in the country. School boards want healthy kids and excellent educational programs. But the Clinton health care reform, as it is written, requires school districts to trade one for the other.

The universal coverage envisioned in this bill offers an enormous opportunity to improve the quality of life for millions of American children. Today, children across this country go to school without proper medical care. Given the obvious connection between good health and educational achievement, it is critical that all American children receive the medical care they need. Universal health-care offers the promise that more students will achieve their educational potential and become healthy, productive adults. This is what every school board member in this country wants.

Yet, in the last years schools have experienced inadequate revenues, increasing educational expectations and ballooning unfunded mandates. A substantial increase in health care costs will deal a devastating blow to many school districts. Fairfax County, Virginia, one of the wealthiest and most highly regarded school districts in the country has worked unendingly at reining in their health insurance costs. They estimate that the Health Security Act would increase their direct health-care costs by 16%, excluding any estimate on what the administrative costs will be.

Further, compared to other units of government, school districts will not have an offsetting savings under the Clinton health-care reform plan. For example, a county or city could pay more as an employer, but save on the operation of its public hospitals. Conversely, school districts could see their health-care costs rise even more since school employees, who are usually younger, healthier, and have safer jobs than the general population, would be included in a larger community rating system.

Although school district budgets are sizeable, there is very little discretionary spending in them. Most school systems pay \$3 out of every \$4 in employee wages and fringe benefits. The remaining dollar primarily pays for facilities operation, debt service, heating and cooling, school bus replacement, and current unfunded mandates, with only a portion left for new education programming. In 1991-1992, the average school district spent 3.5% its budget on discretionary expenditures, which were required to span short-term interest payments, and new innovations, among other items. To increase our health-care costs will require us to make cuts elsewhere -- which means cutting teacher positions, increasing class sizes and diminishing educational programs.

On the revenue side, the picture is not any brighter. The federal government's expenditure in primary and secondary education is less than one percent of the federal budget. The FY 94 appropriations increase for almost every single program was actually less than inflation. The federal government's declining commitment is matched by too many state's funding cutbacks for education over recent years. The increased resource burden falls to the local level, where declining property values have dramatically decreased the local funds to education as well. Since many school districts are affected by property tax limitation laws, or a difficult environment for passing tax levy increases, school budgets are often effectively capped.

III. THE SOLUTION

So the question is how to meet our mutual objective -- to have both healthy kids and excellent educational programs -- to not trade one for the other. Schools cannot be asked to cannibalize their primary mission -- the educational program -- to ensure universal coverage for their employees.

Several components of a solution are:

1. Treat public and private employers the same. The Clinton proposal's double standard applied to public and private employers is baseless -- especially when governments are less favored. The federal government would effectively subsidize health care costs for private employers to the extent their costs rise above 7.9% of payroll. School districts would like the same subsidy. In addition, there is a blanket prohibition against governments -- including school districts -- from creating their own health alliances, thereby eliminating self-insurance. Many school districts' self-insurance has been the way to offer more comprehensive health benefits for their employees. These school districts should be allowed to reap the benefits of self-insurance, just as private employers will.
2. Reduce the employer's responsibility to pay 80% of family coverage for full-time employees and reduce the extent of new employees -- temporary employees, part-time employees and substitute teachers -- that will be added in most school districts. Few school districts in the country currently provide health-care to those employees. For example, in Texas more than 80% of the part-time employees are not included in the district's health plan. New coverage will break the bank on employee costs for virtually every school district in the country.
3. Retain the incentives to reduce workers' compensation health and indemnity claims.
4. Consider very carefully the administrative costs of any system that is created and its effect on the cost of school district recordkeeping. For example, substitute teachers rotate in and out of school district employment on a week-to-week basis.

School boards value the prospect of universal coverage for this nation's school children as well as the school employees who work so hard to serve them. The only question is whether the very substantial costs delineated in this testimony should be paid for by the regressive property tax or at the expense of fulfilling the high educational expectation we all have for this nation's children. The National School Boards Association looks forward to working with the members of the Ways and Means Committee on a health-care reform bill that is good for all of America.

Mr. McDERMOTT. Mr. Melley.

**STATEMENT OF KENNETH F. MELLEY, ASSISTANT EXECUTIVE
DIRECTOR, NATIONAL EDUCATION ASSOCIATION**

Mr. MELLEY. Thank you Mr. Chairman, members of the committee. My name is Ken Melley. I am the assistant executive director of the 2.2 million member National Education Association.

Each day, public school employees work closely with about 10 million children with no health care coverage. Our members are also uniquely aware of the intense competition for resources between health care and public education.

Total spending for health care, public and private, eclipsed total spending for education at all levels, public and private, a decade ago. And by 1990, the total health care spending was twice as much as education spending. Today, it is almost two-and-a-half times as much.

The time has come to equalize the burden of the cost of health care. The time has come for Congress to take immediate steps to bring about comprehensive national health care reform. The end result must be a system that provides universal coverage, not merely access to a broad range of health care treatments and services.

NEA's goal is a tax supported single-payer health care system. Toward that goal, we support reform that provides universal coverage, comprehensive benefits, with the cost shared by the employers, employees, and the local State and Federal Governments.

Any health care reform must bring about significant cost-containment. It must not shift the responsibility for paying for health care from employers to individuals, or from the Federal to State government. Employers must continue their share of health care costs, either through premiums in a system such as the Clinton Health Security Act, or through payroll taxes in a system such as the American Health Security Act, better known as the single-payer plan.

There must be parity between public and private employers, and employees regarding coverage, premiums, and the participation of entities acting as regional alliances.

A Tax Code must not be used to limit access to health care. Employee groups must be able to bargain for benefits beyond any standard benefit package without adverse tax consequences. And current protections against out-of-pocket costs must be preserved.

The NEA pledges to support this committee and this Congress in fashioning legislation that will address the real problems, meet the real needs of children, public school employees, and all Americans.

Thank you, Mr. Chairman.

Mr. McDERMOTT. Thank you.

[The prepared statement follows:]

**STATEMENT OF KENNETH F. MELLEY
ASSISTANT EXECUTIVE DIRECTOR
NATIONAL EDUCATION ASSOCIATION**

Mr. Chairman and Members of the Committee:

I am Ken Melley, Assistant Executive Director of the National Education Association. I am grateful for this chance to speak about an issue that profoundly affects all Americans -- our health care system. NEA members have a unique perspective on the issue of health care. As educators, we are concerned about the gaps in the present system and the impact those inadequacies have on public school students. As individuals committed to enhancing the quality of public education, we are concerned about the growing share of our nation's resources that health care costs consume, especially as they detract from governments' ability to provide adequate resources for education. And as public employees, we have experienced the same challenges as other middle-income Americans in being able to afford adequate coverage for ourselves and our families.

NEA members are keenly aware of the need for fundamental health care reform. The percentage of the non-elderly population without any health care coverage rose from just under 16 percent in 1988 to about 17.5 percent in 1992, and it continues to rise. At least 10 million children have no health care coverage, and as an obvious consequence have little access to any health services or care except in extreme cases. In addition, education employees experience the health care crisis in the intensified competition over resources at the federal, state, and local level. Total spending for health care -- public and private -- eclipsed total spending for education at all levels -- public and private -- a decade ago, and by 1990 total health care spending was twice as much as education spending. Today it is almost two and one-half times as much.

The costs of the present system are so great and the gaps in available services so wide that simply creating larger risk pools or providing limited tax favors will only make it harder for many Americans to get appropriate health care. We cannot afford to delay, nor can we take half measures and hope for the best. This Congress and this President must take action on a health care reform plan that provides universal coverage to a comprehensive set of services and treatments, and that brings about meaningful cost containment.

Any final health care reform plan must assure parity in the treatment of public and private employees and employers. It must not use the tax code to limit access to health care. It must not result in cost-shifting to state and local governments nor to public employees. And it must provide assistance to public school districts to establish comprehensive, integrated school-linked health care services and education.

Mandate for Employer Participation

NEA's goal is a tax-supported, single-payer health care system that provides universal coverage to a comprehensive set of health care treatments and services as the best solution to our nation's health care needs.

At present, approximately 56 percent of all health care expenditures come from private sources, and 44 percent come from public sources. In our view, moving to a single-payer system, that is a system in which premiums are paid from tax dollars and health care services are delivered by a mix of public and private providers, has distinct benefits in terms of efficiency, simplicity, and assuring a network of services -- without eliminating the profit motive or elements of supply and demand that underpin the American system.

We recognize the pressures to maintain an employment-based health care coverage system. Most Americans have become accustomed to the link between employment and coverage. If health care continues to remain employment-based, employers should provide fully paid health care coverage for all employees and their dependents, and there must be parity in the treatment of public and private employees and employers.

The nexus between health care coverage and employment goes back to the beginning of modern labor relations. As early as 1877, labor unions organized health care programs for their own members. By 1948, 10 unions had negotiated health and welfare plans with their employers, and by the 1950s, employer-provided health care insurance became a vital component of compensation for American workers, raising the quality of health care and standard of living for generations of American families. Today, 90 percent of Americans with private health insurance are covered by their own or another family member's employer.

Any health care reform plan, short of a single-payer system, must acknowledge and respect the role collective bargaining plays in assuring that health care coverage is adequate to cover the needs of individuals and families. Federal legislation should not undermine collective bargaining agreements and processes, and any new mechanisms for assuring quality and adequacy of health care coverage should guarantee public school employees and other consumers have a meaningful part in decision making.

Employers who do not provide employee's health care coverage simply shift the responsibility to taxpayers and to more responsible employers and employees who must bear the costs of the most expensive types of coverage -- emergency services and/or extensive treatments for prolonged and postponed conditions. Public education employees have borne the cost of those with no health care coverage by paying for insurance and treatment that is inflated by the hidden cost of caring for uncovered individuals. We believe all Americans should share the responsibility for health care equitably and openly.

Only two proposals introduced in this Congress would maintain the employers' current responsibilities in helping pay for health care. Under President Clinton's Health Security Act (H.R. 3600/S. 1757), most employers would be able to assure employees at the least same level of health care coverage they now receive at no greater cost. And many employers -- including those who now provide no health care benefits to their employees -- would be able to assure employees a much better level of health care coverage than they can now obtain from private insurers. At the same time, it would create a level playing field among economic competitors and enhance our nation's strength by improving the quality of life for millions of Americans. In the same way, the American Health Security Act (H.R. 1200/S. 491) would continue the significant role employers play in defraying the costs of health care coverage by shifting the costs from premiums paid to insurance companies to payroll taxes.

None of the other major health care proposals introduced in this Congress would require employer participation. To varying degrees, the proposals would shift the onus for coverage to individuals to a greater extent than presently exists. In fact, the plan authored by Sen. Don Nickles (R-OK) and Rep. Cliff Stearns (R-FL) would create a mandate of a grossly different kind. It would prohibit employers from providing health care protection to their employees.

Proposals to shift the mandate to individuals would exacerbate many of the current problems in health care coverage. Many low- and middle-income families will, of

necessity, have access only to catastrophic health care coverage. Plans such as the Health Security Act and the American Health Security Act would emphasize preventive care and early detection and treatment, in short, the more effective means of promoting health. A mandate for individuals to purchase coverage would tend to emphasize treatment rather than prevention and emergency treatment at that. Moreover, such proposals would significantly increase the tax burden on middle-income families.

Maintaining employer participation in the costs -- either through premiums or taxes -- would help assure the stability of health care financing. Proposals to curtail employer participation in financing would provide an unprecedented economic windfall to business at the expense of our nation's human resources and the vitality of American families.

Public-Private Participation

Credibility is an important element of any health care reform plan. Americans must be assured that any new system will work and that participants will be well-served under the new system. This need to build credibility is one reason for the Health Security Act's creation of a public-private partnership within the context of regional alliances. And yet, nothing will undermine that confidence of public employees more than the sense that public employees will be treated disparately. Two significant features of the Health Security Act treat public and private employment quite differently: the proposed caps for premium payments and the treatment of existing entities acting as regional alliances.

One function of the regional alliance is to control costs in an effort to stop runaway inflation in health care expenditures, public and private. Capping the premiums employers must pay at 7.9 percent of payroll gives some stability in the system on which employers can rely. Moreover, setting a dual standard -- capping employer premiums for private employers and not capping premiums for public employers until 2002 -- risks the credibility that public employers will be equitably treated, gives more favorable treatment to the largest corporations than to school districts on marginal budgets, and creates the potential for a cost liability school districts are ill-equipped to afford.

NEA strongly urges Congress to adopt provisions that any cap on employer premiums -- such as the 7.9 percent cap contained in the Health Security Act -- apply to public employers as well. At the same time, any sliding scale that caps employer premiums, such as the 3.9 to 7.9 limits according to the size of a private company's workforce contained in the Health Security Act, must apply to public employers as well. Some 8,000 school districts, more than one-half of all school districts, serve 100 or fewer students.

Regarding the issue of the ability of certain entities opt out of the regional alliances, it is clear that any opt out diminishes the ability to pool risks, share costs, and establish a seamless network of coverage. NEA opposes any opt-out of regional alliances or any other system established by federal or state government to provide universal coverage. And yet, if the option for private employers not to participate in the regional alliances remains a part of the health care reform framework, the same option should be available for entities covering public employees and acting in the nature of a regional alliance so long they cover at least 5,000 participants, including dependents. We strongly oppose any efforts to lower the threshold for entities eligible to opt out below 5,000 participants.

Integrated School-Linked Comprehensive Health Education and Services

Among features of the Health Security Act that we believe should be in any final health care reform plan enacted this year are the provisions to provide \$1.5 billion over five years for new integrated school-based clinics run by educators, health officials, and parents, and provisions providing additional resources for planning comprehensive school health programs. NEA believes a comprehensive program of school health education and services must include school health services, school health education, a safe and hazard-free school environment, integrated school and community health promotion efforts, physical education

programs, nutritious food services, school counseling, and wellness programs for faculty and staff. Increasingly, the danger to children's health comes from behaviors, rather than infectious agents. Education, early detection, and a safe and healthful environment in the schools can help promote lifelong wellness habits that will reduce our reliance on expensive treatments down the line.

Health Care and Education: Competition for Resources

Often unnoted in the health care debate is the direct relationship between the increased costs of health care and the decrease in financial support for public education. Over the past decade, Medicaid, as a share of total state budgets, has outstripped support for higher education. At its present rate, total state and local health care costs -- including direct services and the costs of providing health care coverage of public employees -- may well outstrip spending for elementary and secondary education in the near future.

Health care reform, without meaningful cost controls, will only exacerbate the strains at the state and local level to address health care needs, education improvement and renewal, and other pressing demands.

In 1960, spending for health care was approximately \$27 billion, about one-fourth of the \$103 billion spent for all education -- public and private, elementary, secondary, and postsecondary. By 1990, health care spending, at \$666 billion, was nearly twice as much as education spending, at \$365 billion.

State and local governments bear the responsibility for health care services in various ways. As employers, they shoulder the costs of coverage for more than 15 million employees. States share the costs of Medicaid with the federal government, and according to the National Governors' Association, Medicaid costs have risen an average of 26 percent each year over the past three years. Many state, county, and municipal governments also provide direct health care services, including support for hospitals, clinics, outreach programs.

As Members of Congress know well, Medicare and Medicaid costs have mushroomed in recent years. Total public expenditures for health care rose by 269 percent between 1980 and 1990. Medicare and Medicaid costs rose from almost 63 percent of public health care expenditures to more than 67 percent.

Unless health care costs are brought under control, health care expenditures are expected to consume the lion's share of public resources. The National Governors' Association projects that Medicaid costs alone will consume 22 percent of total state budgets by 1995. Between 1980 and 1992, Medicare costs rose from 5.4 percent of the total federal budget to 8 percent; other health care spending rose from 3.9 percent of the total federal budget to 6.4 percent.

NEA supports health care reform that will bring costs under control without diminishing quality or rationing services. As a share of Gross Domestic Product (GDP), health care spending has risen much slower among our economic competitors with a large share of public-supported health care. Much of the difference is the cost of administration. Over the past 20 years, the net cost of insurance and administration rose from 3.7 percent of total health expenditures to 5.8 percent of total expenditures. By contrast, medical research -- as a share of total expenditures -- declined from 2.6 percent to 1.7 percent, and medical facilities construction declined from 4.5 percent to 1.4 percent. Contrary to popular belief, costs of public-funding insurance programs is less than private insurance. Administrative costs for Medicare, for example, are one-seventeenth the cost of private insurance.

Education Employees and Health Care Benefits

Naturally, NEA members, like all Americans, are concerned about the impact of any final plan on them and their families as health care participants.

We are concerned that health care reform not worsen the economic pressures on education employees. Two circumstances of the public schools require some protection against an undue increase in the individual's share of health care premiums. Public employees include a number of part-time staff, both instructional and non-instructional, and public employees, including teachers, are -- as a rule -- not paid as well as other employees in jobs with comparable levels of responsibility or entrance requirements.

NEA strongly supports the cap on the percentage of wage income employees would have to pay for mandated premiums, and we believe it should not be set any higher than the proposed 3.9 percent for both public and private employees.

In addition, NEA has steadfastly opposed the taxation of employee benefits for many years. The Administration's Health Security Act would exclude from taxation all elements of the guaranteed benefit package. And it would exclude, for 10 years, benefits beyond the basic plan that employees have at the time of adoption. These important provisions must be maintained. A number of other health care reform proposals introduced in this Congress -- including the proposals sponsored by Rep. Jim Cooper and Sen. John Breaux (H.R. 3222/S. 1579) and by Rep. William Thomas (R-CA) and Sen. John Chaffee (R-RI) (H.R. 3704/S. 1770) would generate revenues for health care reform by taxing benefits above a very basic, minimal package of covered treatments and services. Such proposals would reverse the efforts of education employees and others who have been able to gain health care security -- at times at the expense of significant wage concessions. More significantly, the taxation of health care coverage above a minimum standard decreases the incentive to assure full coverage for necessary health care treatments and services. In the same way, Section 125 health care plans have helped protect families with significant out-of-pocket costs and should be preserved.

The Administration's plan proposes the imposition of the Medicare payroll tax on all public employees, a change we have opposed for a number of years. We remain deeply concerned that some state and local employees will be subject to this tax, and yet not be able to accrue sufficient quarters to qualify for Medicare by age 65. All public employees should be deemed qualified for Medicare coverage on reaching the age of 65, provided they have worked 40 quarters, regardless of whether or not such work was subject to the Social Security/Medicare tax.

Our members have a growing recognition that the current system is unsustainable. They have felt the rise in health care costs directly in a number of ways -- through increased out-of-pocket costs, limitations in coverage, and the competition at the state and local level for public expenditures for health versus education.

For many years, NEA and its affiliates have worked as partners with state and local officials in addressing the needs of health care costs and benefits. We pledge the same type of cooperation with Congress as it works to shape a final health care plan that will address the nation's health care needs, especially as it affects children.

Thank you.

Mr. McDERMOTT. Let me begin by asking a question of Mr. Motley.

You mentioned a survey that found that 3.5 percent of payroll, people would begin laying off employees. Is your testimony here today that your organization would never support any broad-based tax, payroll tax, premium, whatever, to get universal coverage in this country?

Mr. MOTLEY. No, Mr. McDermott, it is not that.

I think that you could probably take the ones that you have outlined and break them into groups. We certainly are adamantly opposed to an employer mandate saying—which to us says that employers have the responsibility for providing for the health care of everybody who works in this country. In terms of payroll taxes, those would be the most objectionable, because they are not tied to the profitability of a firm at all. They have to be paid and you could be going out of business and still have to pay them.

We have supported plans put forward by members of this committee which have tax increases in them. They tend to be targeted. We support an employer cap, and in the poll that I just mentioned, our members supported a cap on the employer deductibility.

Mr. McDERMOTT. But you are saying that if we are going to tax small business, it should be a corporate profit tax; you would not object to that as strenuously as some of the others?

Obviously, nobody wants to pay taxes; we understand that. But if you are going to find some money to cover the additional downpayment to get everybody covered, you are saying we would prefer a corporate profits tax?

Mr. MOTLEY. No, I wouldn't say that. Preferably—what we would prefer—if this is—

Mr. McDERMOTT. Or a business profits tax?

Mr. MOTLEY. If we are going to do this—and I think that everybody understands that if we are going to have real health care reform in this country, we are going to try and cover as many of those 37 million people as we can, you are going to have to find some money somewhere to do it.

We would view it as a societal obligation. And, therefore, the cost should be spread throughout the American people, if we are going to cover those who are not willing to cover themselves—not on the business community, not through a corporate tax, not through a payroll tax, which is primarily focused on the business community.

Mr. McDERMOTT. So what you are suggesting is a VAT or some kind of national sales tax or—

Mr. MOTLEY. Well, I wouldn't pick a VAT, but—

Mr. McDERMOTT. Well, tell me. I would like to know, because we had that common ground just for 1 second.

We have to find the money to pay for universal coverage someplace. I want to know what kind of tax you think you could accept. If you are saying the old Russell Long saying, "Don't tax you, don't tax me, tax that guy behind the tree," I could understand that desire, but there is really not—

Mr. MOTLEY. I didn't say that, Mr. Chairman. What I have said is that we not only support, but I do think that we had something to do with suggesting it at one time, that one of the ways that you should go about this is to cap the deductibility of health insurance

premiums, not only for employers, but also the tax-free transfer to employees. It would make more educated consumers in the marketplace; it would deliver a tax deduction to people who do not have it now, who have to purchase their own health insurance; and it would raise, according to the administration's figures, between \$30 and \$35 billion a year.

Now, that is a pretty good start. That is a pretty good start on finding funding.

There are other measures like that that we would probably find supportable. If those types of measures don't work—and this is a problem that we have to deal with as an American people—then I believe that our members feel that the cost should be spread throughout the American people evenly, and not placed on the business community through some sort of a special tax.

Mr. McDERMOTT. But can you understand the objection to that proposal? Let me just lay it out for you.

Mr. MOTLEY. Sure I can, yes.

Mr. McDERMOTT. You are essentially saying that the way to control costs is to put the responsibility on the consumer, on the person, on the individual. And that it is really the consumers who are driving up costs in the health care system.

The Cooper plan places an income tax on people with plans above the minimum package in your area. OK. He is saying that the reason the middle class, who have a bigger package, use that package so much and drive up the costs is because they don't make choices. So we have got to force them to make those choices through the tax structure.

But most of those decisions are made by doctors and hospitals.

Mr. MOTLEY. I would approach it a little bit differently, Mr. Chairman.

First of all, I probably testified 100 times before this committee on changing tax incentives in the code. It is something that you all do every year. We did—as Mr. Archer knows and let me know about—support the 1986 Tax Act, which took an awful lot of incentives out of the code for the business community.

We have looked at the deduction provided for the business community as an incentive to get employers to purchase health insurance. We don't see any reason why certain firms should be allowed to subsidize 20 percent of payroll while firms that have done a good job in providing health insurance and are at 6, 8, 9 percent only get that type of the deduction.

What we are saying is, establish a standard plan where you can figure out what the deductibility is. The incentive is still there; you are still telling employers to go out and purchase it, but there is no way that we should subsidize Chrysler at 21 percent and now come along and not even provide 25 percent deductibility for the self-employed in this country. So we have to do something to change the incentives.

You change incentives all the time, and if we can pick up \$35 billion doing it, and the cost of the Cooper and the Chafee and the Thomas bills are sitting somewhere in the neighborhood of \$40 to \$50 billion, it seems to me that we have raised a significant amount of money to begin the process. It may not be the end of the process, and there are other tax changes that—you know, while we

certainly wouldn't like to support, we have said in the past that we would support changing some of the excise or sin taxes out there.

And we have made other suggestions that, frankly, I would like to keep to myself, to various members of the committee.

Mr. McDERMOTT. And I would like to draw out into the public your other suggestions.

Mr. MOTLEY. Well, they would show up in the next chairman's mark, somewhere, Mr. Chairman.

Mr. McDERMOTT. I am going to ask one further question and then stop. What percentage of payroll do you think an employer cap should be at?

Mr. MOTLEY. That is a good question.

Well, I think one of the few reasons that we have come to the position of supporting a standard package of benefits, which frightened us in the beginning because, frankly, one of the real problems small business owners have with the cost of health insurance today is mandated benefits at the State level, which become in effect a standard package in each State. And that frightens us because it can drive the costs through the roof.

But one of the reasons we have come to that position is, if you don't have a standard set of benefits, then there is no way that you can determine what a proper deduction is. I think it should be—you have to decide on the package of benefits first, then tie the deduction to the package on an actuarial basis. We would prefer to see it tied to the actuarial value, plus, so that you would have some room for competition and flexibility above it.

In the Cooper proposal, though, it is tied to a very firm actuarial value. We don't particularly think that that is the best way to go.

But I think the key is having a standard benefits package that you can put a price tag on, and then—and there have to be regional variations, rural versus urban variations, because of the cost; and then you tie the deduction to that.

Mr. McDERMOTT. Sure sounds like we have got some common ground with the single-payer benefit package.

Mr. MOTLEY. I can give you good news and bad news on that from my members.

Again, Mr. Archer will probably cringe when I say this, but over the years as we poll single-payer, more and more small business owners tend to view it as a solution. Now, mind you, still three-quarters of them are opposed, but 10 years ago, 85, 90 percent of them were opposed.

The other side, though, is that their skepticism of government being able to do anything well continues to rise. And again in the recent polls we got back, they don't want to turn the American health care over to the government.

Mr. McDERMOTT. Mr. Archer will inquire.

Mr. ARCHER. Thank you, Mr. Chairman.

In your poll of your members, do you tell them that the single-payer will be coupled with a payroll tax?

Mr. MOTLEY. Well, we didn't have those figures until—I think it was last week or the week before when they were published at 8.4 percent and 4 percent, whatever it was. So, no, I don't believe we said that, Mr. Archer.

Mr. ARCHER. Your part of our hearings is very important. It relates to employer mandates to pay x percent of whatever the health care cost is in this country. But it seems to me that so often we tend to lose sight of what we really are talking about as an issue. And that is quality, available health care, when needed for every American in this country.

We get away from that and we talk about universal coverage, that you have got a piece of paper or a card or a government program. And I worry about that, because we have the highest-quality health care system in the world here in the United States today, where people can go in and get care when they need it and get it quickly and get the best possible quality.

And if I had time, I would disabuse this idea of infant mortality and life expectancy, which is a stalking-horse that is totally inaccurate as to the quality of our health care delivery system. The fact is, we have higher infant mortality because we try harder. We have more technology to keep the premature babies alive beyond the 30 days, and thrust them then into infant mortality statistics, which is the first year after birth.

We have the best record in the world on neonatal mortality, which is the first 30 days of life. But you don't hear about that. And then they translate the higher infant mortality into lower life expectancy, which is an arithmetic mean average, by filtering in these deaths at 6 weeks or 2 months or whatever, which dramatically impacts on life expectancy. But because we try harder and have better technology and better quality, we lose in the statistical game.

The American people need to understand what is involved in this whole exercise, and that is, are they going to have to wait for an operation, are they going to be denied an operation?

It has often been said, well, the overwhelming majority of people in Canada approve of their system. The same is true in this country. All the polls show overwhelmingly, 75 to 80 percent of the people in this country are happy with their medical care system. It is the unusual cases that bring about the concerns. And the unusual cases in Canada come to the United States to get their operations. They don't have an unusual case in Canada.

And we have, of course, the frailty in our system that you may have an unusual case in the United States where you have a pre-existing illness and you can't get insurance coverage, and therefore, you are understandably concerned about our system.

But, gentlemen, why can't we adopt some things that all of us agree on, which is insurance reform that will require that insurance companies writing insurance not preclude existing illnesses and deny coverage, permit portability, permit access to insurance, permit small businesses to pool together voluntarily in bigger groups and get a cost that is equal to what big businesses get? That can be done without nationalizing the system.

What is in the Clinton plan that you gentlemen know of that reduces health care costs while maintaining the same availability and the same quality of health care? Can any one of you tell me something that is in that bill that will directly strike at health care costs in this country?

Mr. MELLEY. Mr. Archer, I can't give a direct answer to that question, but the presumption that you made, that we can do this, begs the question then, why haven't we done it already? And why do we have this problem now?

If in fact it was a free-market system that would allow for universal coverage or access, we wouldn't have the problem we are faced with today. The fact is, it hasn't. And at least the President has made an effort to bring the issue to the forefront.

Mr. ARCHER. The reason it hasn't is because there has been an incentive for insurance companies to select the healthiest people to reduce their premium charges. But there is no reason why there cannot be a requirement in each State that if you want to write in that State, you have to take one, take all. That can be done.

I am just curious, what in the Clinton plan cuts costs for health care? Now don't tell me paperwork, because when he talks about the stack of paperwork, he is not talking about an insurance form, he is talking about the case history of each of those patients. And his plan will not cut that. It will probably increase it because of the new government quality control boards that will have the agents out there demanding more information in case histories.

But what else—what else is going to save money in his plan?

Mr. MOTLEY. Mr. Archer, when I listen to the President talk about cost savings and then I look at the bill and I look at the results of the Lewin studies, I have a disconnect. I tend to feel that the President is talking about the government saving money on Medicare and Medicaid. I don't think he is talking about employers saving money or individuals saving money who are out there facing the same crises that that they have had before.

Again, if 72 percent of the employers in this country do not provide health insurance, by definition they are going to have cost increases; and of those that do, 50 percent are going to have cost increases. It seems to me that a lot of people who have been clamoring for health insurance reform because of cost are going to be sorely disappointed because their costs are going to rise.

The government's costs may go down. That is what we may be talking about; and I have listened very carefully, and I really do think that that is what the President talks about, because he talks about it in terms of a Federal budget context in crisis.

So we are talking about savings for the Federal Government, probably savings for individuals, too, but certainly not for the people who are paying for the health insurance.

Mr. ARCHER. OK. Thank you, Mr. Chairman.

Mr. McDERMOTT. Mr. Ford will inquire.

Mr. FORD. Thank you very much, Mr. Chairman.

Mr. Motley, I have one question for you. Do you have information on whether the majority of small business owners currently provide health insurance coverage?

I see that on page 6 in your testimony, you talk about the percentage of firms that do and do not offer health insurance. You go on to talk about the firm size, indicating that among firms with fewer than five employees, 26 percent offer health insurance and 74 percent do not. Your testimony then discusses firms with 5 to 9 employees and goes forward through firms with 100 or more employees. I can't really tell by what percentage these five categories

represent a majority or nonmajority of small businesses in this country.

Do you have any information as to——

Mr. MOTLEY. We could expand upon that for you, but those figures—in and of themselves, it depends how we are going to define small business. What happens, Mr. Ford, is that there is a tremendous relationship between the size of the business and whether it provides health insurance. The very smallest firms——

Mr. FORD. Is there one industry over another industry, whether or not——

Mr. MOTLEY. No, just straight across the board census figures. The smaller the business, the fewer the number of employees it has, the less likely it is—it is most likely not to provide health insurance. That is what the 74 percent is.

Mr. FORD. Any information as to the five or fewer employees? What percentage would they represent overall of small businesses? Is there any way of knowing that?

Mr. MOTLEY. They represent 60 percent of all of the employers. This is according to the Census Department, 60 percent of all of the employers in the United States have four or fewer employees. There are only 8,000 firms that have over 5,000 employees in this country.

Mr. FORD. Because after the 5 to 9 employees and on up to 100 and over, the vast, vast majority of small businesses, you know, provide health insurance.

Mr. MOTLEY. They don't.

Mr. FORD. According to your charts, I am speaking of.

Mr. MOTLEY. That they do provide?

Mr. FORD. Yes, they do. They offer, with 5 to 9 employees, 50 percent or more, 54 percent or more; 10 to 24, 72 percent of the small businesses offer it; 25 to 49, 90 percent of all small businesses offer it.

Mr. MOTLEY. Well, those are incremental numbers, Congressman Ford.

What it basically says, I believe—the chart in there—is that the vast majority of the smallest firms in this country do not provide. And that is almost three of four do not provide. And that is——

Mr. FORD. Only in that one category.

Mr. MOTLEY [continuing]. That is 3 million of the 5 million employers you have. There are only 5 million employers in the United States. The whole universe is 5 million firms, between 5 and 5.1 million, depending upon when we look at that.

Mr. FORD. I know you are speaking of employers. I am going by your charts, on the number of employees the employers——

Mr. MOTLEY. Employees, my understanding—and I don't have the chart in there, but my understanding is that roughly two-thirds of the employees of the American business community have privately held insurance.

Mr. FORD. Over two-thirds?

Mr. MOTLEY. Over two-thirds, that is right. So the ones that don't are heavily clustered at the bottom end.

If I may add one other point here, because I did make this point to the Governors in August, in this group of four and fewer are almost all minority businesses in the country. The average employee

size for minority businesses in the United States, of those having employees, is 3.1. They represent about 10 percent of the total community, about 4 percent of the receipts, but their average employment is only about three employees per firm. So they would be amongst the group that does not provide insurance, and would have significant new costs under this proposal.

Mr. FORD. All right, OK.

Thank you, Mr. Chairman.

Mr. McDERMOTT. Mr. Thomas will inquire.

Mr. THOMAS. Thank you, Mr. Chairman.

Mr. Motley, one of the things that I think you might want to focus on that we got out of Martin Feldstein's numbers was that for all the talk about major unemployment, he estimates it is only going to be about 0.5 percent unemployment. But that total figure camouflages all of the churning that will be going on at that lower end of the business ladder and particularly for the small businessman; and when you have four employees and lose one, that is a 25 percent employee loss.

Normally those folks tend to be at the lower wage level, and for good reason I think, the President is talking about combining welfare with health care, because those folks more often than not wind up somewhere on the welfare lists if they aren't able to find another lower-paying job. With the imposed health care, they will be moving and so it is churning, as well, the actual unemployment.

Second, you made your passage of growth and understanding of the problems sound very painful, and I don't think you should. What I mean by that is, you said you came to the understanding that you needed to have a standard benefits package. I followed the same route in trying to figure out how to address our problems. You said you wanted a standard benefits package plus. I started with a dollar amount, and I understood then that under the dollar amount, people would be packaging health care in a way to create adverse risk selection.

If you have a standard benefits package, plus, you still have an ability to mold a benefits package to fit particular groups, you are back into the adverse risk selection. So I came reluctantly, but knowingly, that a standard benefits package with a tax cap was the fairest way to make sure that industry offered some equity across the board; and that above that, whatever people want in terms of additions would be paid for out of aftertax dollars.

But we are sitting here as a Federal Congress listening to you address the national government, and we continue to act as though nothing has been happening. And that is just not true.

If you look at what is going on in States over the last several years, and I will use California as a model because, frankly, I didn't think trial lawyers and the medical industry would get together on a major fundamental malpractice reform program. They have done it. We need to do it at this level. Many, many States have passed insurance reforms.

We talk about the prior condition aspect, portability. But we also see a number of States creating the opportunity for small group purchasing reforms. We need to do that at this level.

So we need the insurance reforms, we need malpractice reforms, we need the antitrust reforms, we need the administrative sim-

plification that is going to be part of any package. Those are significant restructurers of how health insurance is going to be offered.

Mr. Melley, you need to know that I am a teacher on leave, and I negotiated for both a certificate in the classified employees and a very large community college district for 10 years. And I just have to tell you that basically what I heard you say was you wanted a floor, you want the single-payer, you want somebody else to pay for it; but then you don't want a tax cap, so that there is no ceiling, and that whatever you can negotiate on top of that floor, you want.

You are part of the problem. When you talk about needing some discipline in terms of individuals, in terms of, one, what they need versus what they want versus what they should be using, the very idea that you want someone else to pay for it and then not be subjected to any kind of a limit, so that you can go out and get whatever else you can add to that is, frankly, not much help in trying to come to a resolution of the problem.

Let me ask you a simple question, because you said you were for the single-payer. Are you for the President's plan?

Mr. MELLEY. We are for the major elements of the President's plan.

Mr. THOMAS. That wasn't my question. Are you for the President's plan?

Mr. MELLEY. We are for the President's plan in its major elements.

Mr. THOMAS. Let me try it again. If 3600 as introduced was passed, would you be supportive of it or opposed to it?

Mr. MELLEY. Of course, if it were passed we would be supportive of it.

Mr. THOMAS. OK, so you want to make fine tunings, basically, take off the limits that are in there?

Mr. MELLEY. We engage in the legislative process with a goal of having a single-payer. We believe the President's plan is a step in the direction of the single-payer—

Mr. THOMAS. Oh, please say that again.

Mr. MELLEY [continuing]. That will allow—

Mr. THOMAS. I want to underscore that. You believe the—the National Education Association believes that the President's plan is a first major step toward single-payer?

Mr. MELLEY. It will allow for our State governments to adopt single-payer options, and we would support it in that regard.

Mr. THOMAS. So it has the seeds of the single-payer in it, and you hope that they will bear fruit and blossom?

Another way of putting it. Do you believe—

Mr. MELLEY. Can I answer the first question you asked, though, about the—

Mr. THOMAS. Let me ask a question, because my time light is out, and it is simply this. When you say you want universal coverage, do you believe that you can have universal coverage if there are deductions or copayments placed upon the individual?

Mr. MELLEY. We currently now have sharing of premiums for most of the plans that we are in. We currently have copayments for most of the plans we are in. And we currently have deductibles

for most of the plans we are in. We presume that would be the case in the final analysis.

Mr. THOMAS. So you do not preclude deductions or copayments as part of a universal coverage package?

Mr. MELLEY. No.

Mr. THOMAS. OK. You need to know, there are some people who do, and I appreciate that difference. Thank you.

And on somebody else's time, if you want to answer that other question, or if the chairman is willing to let you, go ahead and continue. I am more than willing to let the chairman—

Mr. McDERMOTT. No, he said just quite enough.

Mr. THOMAS. I guess somebody's rose is someone else's thorn.

Mr. McDERMOTT. Mr. Hoagland will inquire.

Mr. HOAGLAND. I have no questions, Mr. Chairman.

Mr. McDERMOTT. Mrs. Johnson will inquire.

Mrs. JOHNSON. Mr. Chairman, thank you very much. I want to say, first of all, that I think to some extent the tax issue is a bogus issue. The Cooper bill is not a middle-class tax increase. Under the Cooper bill, you get complete protection for the lowest-cost accountable health plan. In the Thomas-Chafee bill, you get complete protection for a much higher level. We can put that, as far as I am concerned, at the average accountable health plan. All we are trying to do is focus the market competition at a more reasonable level and stop subsidizing first dollar coverage, Cadillac plans.

The President's plan has a tax cap in it. It is just 10 years out. That is politics; that is not health care policy. So everyone agrees we should be trying to reuse the money in the system.

You asked, Mr. Melley, shouldn't this nation have universal coverage? We did. When Medicare paid usual-customary and when insurance was community rated, we had a national universal health care system, and it was rising costs that broke it. That is what caused the underreimbursements in Medicaid and gradual diminishing of access for Medicaid recipients. That is what caused risk selection, that is what caused premium variations.

So unless we do something about cost control, we will never make it; unless we stop subsidizing first dollar coverage, Cadillac plans, we are never going to make it.

But to get to the real issue for this panel, and that is your skepticism about whether or not there will be money enough for the subsidies, and whether the subsidies will help. I want to point out to you, and I want to ask you how many of the companies that you know would be eligible for subsidies? It has come to my attention that maybe one or two companies in Connecticut will qualify for that 3.5 percent. You have to have an average salary of zero to \$12,000; \$12,000 is under poverty in Connecticut.

The likelihood that you are a two-employee business and neither one of you is making more than \$12,000 is almost zero.

Mrs. JOHNSON. So the number of employers that are going to get that 3.5 percent benefit is essentially zero.

The next category, 4.4, your average salary has to be \$12,000 to \$15,000. Now, that is pretty low, \$12,000 to \$15,000. Connecticut is a very high cost State. That is why our health care costs are high.

The next category to get a 5.3 instead of 7.9, your average salary—and you have 25 employees—has to be \$15,000 to \$18,000. Now, there are a lot of folks out there thinking they are going to get a subsidy, and I need to know from you, and you need to get us some hard figures back, how many of these small businesses in America will be eligible for 3.5? I can you tell in Connecticut it will not be any. These income levels are not indexed. Not indexed. So they are going to creep quite rapidly. At least at the rate of the cost of living.

So I think you are right to be concerned about subsidies, and I need your input on their availability, and I need to remind you that in terms of comprehensive health care in America, it is too bad you were not here for the panel we had yesterday, because America is doing it. We had three groups testifying as to how they have reformed Medicaid to create universal access for all Medicaid-eligible people to comprehensive care systems and then have used those systems to offer low-cost plans to small business.

In San Diego County, in Boston, which now covers all of Massachusetts—this plan now covers all of Massachusetts, you did not hear that, did you? Nobody knows that. That is within existing resources. That is no new taxes. That is the private sector working with the public sector to better use our resources.

So one of the very important things here is not to get too caught up in the tax issue because we have to use our resources better. And to be well-informed about what is happening out there already. And when you get Arizona, California, Massachusetts succeeding, you better wake up and smell the roses, especially before you say small businesses in Connecticut are going to have at the minimum 4.4 percent.

So I want you to comment on these average salaries versus the subsidies. I mean, this is the nuts and bolts of the President's plan. This is not the rhetoric about how we understand small businesses cannot pay; we are going to help them. Now, who are we going to help here exactly? And who are we not going to help?

John.

Mr. MOTLEY. Congresswoman, it is our understanding neither the Small Business Administration nor the Bureau of Labor Statistics have current figures on what average wages by firm size are, therefore, there is no way of estimating or answering your question how many firms are going to be eligible.

I think it is probably going to be regional. It is going to be what types of businesses are located. I think there is a lot of things about the subsidy or the caps that concern us, not only that we really cannot figure it, but now I believe in the President's program there is a cap on the cap, or at least the amount of money available for the cap. And if we cannot estimate it, we could have a lot more businesses out there eligible for it than we think. And the way the President would like to see it done, is that when we reach the cap, there is no more money left to pay the subsidy.

In addition, between the time the proposal was announced and it was finally brought up to the Hill the cap had changed three times. There is an illustration of that in my testimony.

Mrs. JOHNSON. I invite you to get back to me on this, but I brought up earlier the incentives in this bill for companies to re-

structure so their low-paying jobs are separate. From my point of view, where New England is in a catastrophic economic tailspin, this will be another incentive for New England companies to restructure low-paying functions to other regions, the South and other areas, where they have much lower wages and they currently do not offer health benefits so they get much bigger subsidies. And the underlying geographic shift in wealth behind this bill ought to be of enormous concern to every midwestern and New England legislator.

Mr. MOTLEY. Congresswoman, look at the flip side of what you said, too. Doesn't this discriminate against people who want to create higher paying jobs?

Mrs. JOHNSON. Absolutely.

Mr. MOTLEY. If you are a normal employer, you will start taking a look at the salary levels you pay people.

Mrs. JOHNSON. And you are going to start doing exactly what some of us in our offices are forced to do. We are forced to keep certain jobs low paying and just accept the turnover. And that is what is going to happen.

If you are at 3.5 and an increase for your staff would mean it brings you into the next category of a 4.4, that is quite a lot. That is a .9 percent increase in your payroll tax for health care. You will make darn sure the salaries do not go up and you just accept the turnover.

So we are talking about the quality and talking about the cost. Thank you.

Mr. McDERMOTT. Mr. Kopetski will inquire.

Mr. KOPETSKI. Thank you, Mr. Chairman.

It seems to me that this Nation has to worry not so much about losing these low-income jobs to another region of the country but to other places in the world. We are currently under a debate of opening up, lifting the embargo on Vietnam, for example, which I support, but also the fact of life that we see a shift of businesses to that nation because of low-cost wages.

On the other hand, in terms of the more higher paying jobs, which surely is the U.S. future, if you look at Germany, where they have better average salaries for their workers than what we provide in the United States, they provide comprehensive health care coverage for all their workers through an employer mandated system. Germany is our competitor. We have to recognize that. They are today and they are going to be 20 years from now. The issue is how are we going to be competitive with them.

Our costs are skyrocketing. You have seen this, Mr. Motley. It costs a lot more to manufacture a car in the United States than in Japan or Germany, if you look only at the cost going into that automobile of providing health care coverage to the workers. So how are we going to get it under control? That is what we are talking about today, is getting that under control so we can be competitive. Not doing something is not an answer.

And Oregon, Mrs. Johnson, is one of the States that has worked on the Medicaid issue and came up with a reform. But I met with the Governor yesterday and she said, look, it ain't gonna happen in terms of Medicaid utilization unless it is accompanied with the

employer mandate. It is part and parcel of that Medicaid expansion.

The State of Oregon added 125,000 people to Medicaid eligibility 2 days ago, but part of that means you keep people out of the Medicaid program who are working, who are working in jobs and do not have to go to the government for health care. They get it, as most people do in this country, and that is through their employer.

My question, though, is really in the public employee sector, Mr. Melley, and that is, I was looking at your testimony on page 5 where you say that there ought to be a cap on premiums for both the public and private sector, and I think the private sector has been ignoring that fact out there and they have not educated their people about what is in the President's bill in terms of this cap.

It is my understanding that currently the cap does not apply to the governmental, local governmental sector; am I incorrect.

Mr. MELLEY. That is correct, Mr. Kopetski.

Mr. KOPETSKI. So you are suggesting it should be expanded to cover State and local government as an employer as well?

Mr. MELLEY. Yes.

Mr. KOPETSKI. Do you want to talk about that? Is there a justification for that?

Mr. MELLEY. It is the issue of parity and fairness.

Mr. KOPETSKI. Parity between public and private?

Mr. MELLEY. Parity between public and private. In fact, if there is a cap that is designated for the private sector and no control on caps for the public sector, the chances are the public sector, in its entertaining potential plans in the future, would have a higher percentage applied in their payroll tax.

Mr. KOPETSKI. Seems to me one of the new messages, or an old message being renewed and sent to the Congress from all of our local governments this year is no unfunded mandates. And what we are saying, if we leave the cap off of the public employer that we are saying to them, well, you have a deep pocket, you can just reach in further, i.e. into your taxpayer to fund this.

Mr. MELLEY. That is correct. That is true.

Mr. KOPETSKI. I have a half minute left. Did you want to answer Mr. Thomas' other question?

Mr. MELLEY. I wanted to ask him if he was an NEA member when he negotiated that contract in California.

Mr. KOPETSKI. He is one of the most fair people we have. I am sure, even if he was not a member, he would have done a great job.

Mr. MELLEY. No, I will pass.

Mr. KOPETSKI. Mr. Resnick.

Mr. RESNICK. Representing school boards, who are public employers, Mr. Kopetski, we deal with a very finite tax base. We cannot pick and choose our communities. There are many poor communities in this Nation, who have low-paid workers and also have very modest health programs. By virtue of introducing a comprehensive health program, those school district costs will go through the roof relative to their budgets.

We are a very highly labor-intensive industry, and many school districts will not be able to afford the additional employee benefits expenditure, particularly within such a short period of time. Unless the 7.9 percent subsidy is provided, we are going to watch a decline

in those very school districts that have the hardest trouble in making educational achievement by virtue of their low tax base.

Mr. KOPETSKI. I agree with you and I think we should have the mandate out there, but I also think that local government should have the cap as well for the parity issue that Mr. Melley has talked about.

Thank you, Mr. Chairman.

Mr. McDERMOTT. Mr. Pickle will inquire.

Mr. PICKLE. Thank you, Mr. Chairman.

Mr. Motley, I am going to be seeing some of your folks here in a few minutes, and I am sympathetic to the problem they have, particularly in the fast food area. I am trying to find out to my satisfaction what is the answer to this small business problem. We do have a problem in that field and I am trying to find out where is the equity in there.

So let me say first in the broadest sense that I think we have all agreed that one way or another we will probably have to reach the status of universal coverage. We do that now. That is, if an individual needs help, he goes to the hospital, we pay for that 38, 38 million one way or the other. So we are proposing now we pay for it up front. We have to have money to pay for that and we have to get it either from the tobacco tax or Medicare and employer mandates in some proportion and perhaps others, but anyway that is how we generally go about it.

So my first question to you is, if we are going to give this kind of coverage and this kind of protection, and if you want fast food, for example, to be exempted, how do we pay for that? How does that cost get paid for? What is your proposal?

Mr. MOTLEY. That is, of course, the very difficult question that you have, Mr. Pickle; where do you get the money to go to universal coverage. And by and large NFIB members support universal coverage.

I think the thing that bothers us as we take a look at it, though, is the willingness of the administration and those in Congress to trade jobs for universal coverage. That we think is the wrong trade.

Of all of the proposals that are out there, whether they be Mr. McDermott's proposal, Mr. Thomas' proposal, Mr. Andrews' proposal, the President's is the only one we see so far that trades jobs for universal coverage, and we think that is the wrong trade. That is our major disagreement.

Mr. PICKLE. Mr. Motley, you make the comparison between jobs and universal coverage. I think it is a broader question than that. I don't want to argue that question with you, but you can make a good arrangement if you want to look at it just in that light.

My concern is that we are trying to find some way that everybody pays, or at least we can pay for the service we are going to give them. So if you don't like the President's proposal, it seems to me like we should say, well, then, what do you recommend. As I understand it, you have not said what you would recommend. I don't want to just say, well, you cannot do it because you will lose jobs. I don't know that you will lose jobs.

Mr. MOTLEY. Before you came in, Mr. Pickle, the chairman and I had a discussion on what taxes we would support. We have supported Mr. Cooper's and Mr. Andrews' proposal, we have supported

Mr. Thomas' proposal. Both of those have taxes in it. We support capping the employer deductibility.

Mr. PICKLE. Mr. Motley, I support generally Mr. Cooper's approach. I like the competitive aspect of the bill. I might disagree with the present chairman on it. I don't disagree with you on not having a competitive aspect of it, but I am asking how are we going to pay if we exempt some of your people?

Who pays for that? Just by access? It is an arguable answer, but I don't accept it. And I don't know that I want to endorse the President's. I have a feeling, Mr. Motley, that we have to reach a compromise between—we will say—Mr. Cooper, or that approach, and what the administration recommends. And I think we have to come together on universal coverage or maybe they can find a way. I understand they are working on it. But somehow we have to pay for the people. If we exempt some of your people, you have to have some way to pay for it. Someone has to pay for it.

Mr. MOTLEY. I tend to agree with you. I would posit if it is a problem that the government wants to solve, then the country as a whole should pay for it rather than the employer community. Why should we trade jobs for universal coverage? We can raise income taxes.

Mr. PICKLE. It is not a question of jobs. It is a broader question than that. You are saying if you are going to give it to them then let the country pay for it. Let the public pay for it. A general tax?

Mr. MOTLEY. If it is a societal problem, why should not the public pay for it?

Mr. PICKLE. How will the public pay for it?

Mr. MOTLEY. Mr. Pickle, I think the cheapest way to deal with the problem of 37 million uninsured people in this country would be for the government to just buy them all a health insurance policy. There would be no downsizing or none of the other things we have to worry about finding the money for. The problem is we do not want to tell the people they have to pay for it.

Mr. PICKLE. The answer is you just said the government pays for it.

Mr. MOTLEY. Not the government, the taxpayers.

Mr. PICKLE. Mr. Motley, I do not want to argue. I am trying to get at the point that it seems like somebody—everybody has to pay a little bit on something.

Mr. MOTLEY. That is true.

Mr. PICKLE. I know my time has expired here. I don't know that I am in love with the President's plan, but it takes the larger employers and they will say, for example, if you have 1,000 employees at \$20,000 each, you will have about 20 million and the cap on it would be 7.9; but if you had a really small company, with about 10 employees, you would have an average of about 20,000, then you would have a much smaller cap, 3.5, or even less in some cases.

Now, if that is not workable, then what do we use? That is one approach. And I don't know that I want to just buy that, but I am trying to see what is fair. You say, then, well, if you were going to give universal coverage then the government ought to pay for it. So I am asking you how does the government pay for it? You want to tax everybody 1 percent on their income tax to pay for your employees?

Mr. MOTLEY. Mr. Pickle, as I said to Mr. McDermott before, NFIB has supported revenue raisers which raise considerable amounts of money, the one that I mentioned, which is capping deductibility, it is between \$30 and \$35 million. That certainly is a start. We have supported increasing what is called sin taxes or excise taxes. That is additional money. There are other revenue raisers that, in a package that we believe would do the job, we would have to consider. I mean, there are all sorts of ways we can raise revenue.

Mr. PICKLE. I would like to have those ways suggested to us rather than be rather evasive.

I talked to the chairman and he said he was not satisfied by your answers. I want to find out if you do make exceptions, we do not cover you, who pays for it. I think we have to be honest about that and that is eventually where we have to end up.

Thank you, Mr. Chairman.

Mr. MCDERMOTT. Mr. Payne will inquire.

Mr. PAYNE. Thank you very much, Mr. Chairman, and thank you for testifying.

I, too, have concerns about the employer mandate as I have tried to understand how we can achieve universal coverage. It seems now we have 85 percent of our population that is covered and 15 percent that is not, and of the 15 percent of the population that is not, there are a number of things we might do to help cover that percentage of the population.

For instance, we could ensure that everyone up to 100 percent of poverty is, in fact, covered. We could subsidize those people who are between 100 and 200 percent of poverty, to make insurance more affordable. We could provide tax benefits to self-employed individuals. For instance, we would allow them to fully deduct the cost of their health care plans. And we could remove barriers that exist for people with preexisting conditions by having community ratings and that sort of thing.

By doing or taking those steps first, we would then eliminate a part of the 15 percent. It is very difficult to know precisely what part of that 15 percent is eliminated, but it seems to me it might be a substantial part and then we might be able to target those people who are not then covered, which would be a very small portion of the population and make some determination about a more specific way to go after them than a universal employer mandate.

It seems to me that that is one way to approach this issue which might get us to universal coverage just as quickly as any of the other plans we are speaking of. I would just invite any comments that anybody might have about a system like that as a way to get to universal coverage.

Mr. MOTLEY. Mr. Payne, first of all, I think you do have one laboratory out there and that is the State that went to universal coverage through an employer mandate a couple of decades ago, and that is Hawaii. And the fact of the matter is they do not have universal coverage. Somewhere between 3 and 11 percent of the population is uncovered.

So an employer mandate is not necessarily the total answer to the question. In fact, you could argue if it does cause the types of low-wage job destruction that some economists says that it would,

those people would lose their jobs and be thrown on to public assistance, which just creates a problem on the flip side.

We have been very supportive over the years, and most of the business community has been, of the type of legislation put together by the chairman of this committee last Congress, that Senator Bentsen took forward when he was a Senator, and passed in the Senate two times, which are many of the things you said there, and which I think is the general philosophical positioning of Mr. Cooper and Mr. Andrews, and that is, let's do all of the things we know have to be done and that we all agree upon doing and see how much of the problem that we solve. And then let's come back and argue about how we are going to cover what remains.

I think that has been the huge philosophical debate we have had here for the last 3 years and the reason we never considered that on the House floor during the 2 years previous to this is that people realize that if that happened then there would be less channels of moving to a more grandiose solution such as the ones we have before us today.

So I think from NFIB's standpoint and HIAA, which is the largest coalition of employers, and a whole group of other people would strongly support the approach that you have just outlined.

Mr. PAYNE. Mr. Motley, are you aware of any States that have any kind of programs that provide incentives for small businesses to provide health care coverage for their employees, ones that truly are successful?

Mr. MOTLEY. I hesitate because I might misspeak. What I would prefer to do there is to get you the information and provide it to you on State programs. I am not sure whether Florida provides an incentive or not. We worked closely with Governor Chiles in the proposal that has passed the Florida legislature and is being implemented right now, which is a variation of managed competition.

There are some discounts that are involved in that for small employers that purchase the standard policy for certain types of employees. Very inexpensive. I think it is about \$50 a month per employee. It is not a bare bones package at all.

I would urge the committee to take a look at what Florida has done. It may not get you to where the President wants to go, but it certainly is a forward looking proposal that a lot of people have supported and now want to see how well it is going to work.

Mr. PAYNE. Thank you very much. Thank you, Mr. Chairman.

Mr. McDERMOTT. Mr. Sundquist will inquire.

Mr. SUNDQUIST. Thank you, Mr. Chairman.

First of all, I would like unanimous consent to put a statement in the record stating my opposition to the provision in the Health Care Security Act that calls for employer mandates as a means of providing universal coverage.

Mr. McDERMOTT. Without objection, so ordered.

[The prepared statement follows:]

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Statement of Congressman Don Sundquist (R-TN)
Submitted for the Record
Committee on Ways and Means
February 3, 1994

Mr. Chairman, I strongly oppose the provision in President Clinton's Health Security Act that calls for employer mandates as a means of providing universal coverage.

As someone with years of experience in small businesses, I see an employer mandate as a payroll tax on employment. Such a mandate must be paid regardless of a firm's financial health. It will force increased costs upon already strapped businesses, which by definition must result in lower wages or fewer jobs.

When asked in an NFIB poll how they would be affected by a 3.5% increase in payroll costs, one third of small business respondents said they would let employees go, and nearly one half said they would be forced to raise prices. Even the Clinton Administration has acknowledged that approximately 600,000 jobs could be lost.

Dean Gillespie, of McMinnville, Tennessee, owns one of those small businesses. He has said, and I quote: "Bridge Builders, Inc. is struggling to continue furnishing health care insurance for employees and families--with employees sharing one-half the cost. Today, if we were required to do much more than we are already doing, then we may as well close the doors and let the government take care of us."

Most employers that can afford to do provide health benefits for their employees. We need to focus on bringing down the costs of care so that more employers can afford to offer coverage.

If attempts at providing health security for employees results in threatening their job security, they have not necessarily been benefited at all. I urge my colleagues to reject this provision.

Thank you, Mr. Chairman.

Mr. SUNDQUIST. Sorry I am late, and there is a vote on so I will just ask one or two questions, and I apologize if this is redundant.

I would like to ask Mr. Motley about the mandatory payroll tax, with the payroll tax cap and these other things. If we proceed on that basis, what we are doing is we are going to lower the investment in the cost for big business, big corporate business, national and international, and we are going to put this on the backs of small businesses and we are going to ask small businesses to bail out corporate big companies in America. Is that a fair assessment, Mr. Motley?

Mr. MOTLEY. Well, back in September 1993 there was a chart in the Business section of the Washington Post which would certainly indicate that to be true, Mr. Sundquist. For firms with 25 or fewer employees, the first year costs were over \$25 million. With firms that had more than 1,000 employees, there was a reduction in costs of \$8 billion. So there seems to be certainly some sort of leavening.

It looks strangely to me like a form of industrial policy, in which we want to pick those firms in the economy that we want to help right now and let the others pay for it.

I think the big problem that you have, and I mentioned this first of all in my statement, is that there is really a misconception about the number of employers in this country who provide health insurance. And it is a very, very significant number, probably somewhere in the neighborhood of between 55 and 60 percent do not. Therefore, any costs are new costs.

And even at 3.5 percent of payroll—and I think all of you, if you go out to your districts and walk down Main Street of some of the small towns that are having problems, and you walk by the fronts of small businesses, and you know the ones I am talking about, even 3.5 percent of payroll is going to be a problem for them. And that has been the problem with this whole debate for 10 years.

If you increase those costs—and the people who work for them who do not have health insurance tend to be congregated within 150 percent of the poverty level. So you have very marginal employers who are employing very, very marginal workers, and I think that is dynamite. Because what will happen, as employers adjust, they can either just raise their prices, they can take less in profits—which some will do—or they will adjust their payroll. And as they adjust their payroll, a significant number of them will let people go.

That is where the problem lies and the problem that we cannot solve in this.

Mr. SUNDQUIST. One last question, and that is, do you have any numbers that would give us an indication of the corporations or big businesses in this country that would have a bottom line break if they are at 14 percent, 13 percent, 12 percent, 15 percent of payroll costs now, in terms of health care, and how much that would make—what a difference that would make with x number of big corporation jobs as opposed to what it would cost for the average small business?

Mr. MOTLEY. I will use approximates.

Mr. SUNDQUIST. If you can give them to me, I will put them in the record also.

Mr. MOTLEY. Oh, we can give them to you. It is my understanding that all three major auto manufacturers in this country have payroll costs for health care of around 20 percent of payroll, which is very significant.

Individuals who testified on the first panel for the retail industry indicated that their costs were between 6 and 7 percent of payroll. So there is a huge difference across industry lines and types of businesses and how they are organized as to what the cost of payroll is, and that is why so many firms will have increases under the President's proposal.

I believe firms like Kodak are at around 12 percent. So you have really significant differences. And not only that, the government's picking up of retiree health care benefits is a huge, huge benefit to firms like General Motors. I believe the first year increment is probably somewhere over \$20 billion a year that would increase their bottom line. So there is significant help for very, very large businesses, particularly industrialized, unionized businesses in this country at the expense of others.

Mr. SUNDQUIST. Thank you. Thank you, Mr. Chairman.

Mr. McDERMOTT. Mr. Levin will inquire.

Mr. LEVIN. Well, Mr. Motley, if there were time, I think it would be useful to talk about where the balance has shifted, and I really question whether it is fair for smaller business to say that manufacturing in this country has not carried its weight in terms of health care. I really think that is a way of ducking the problem by pointing the finger at one of the areas where such a tremendous health care load has been carried, including employees of smaller business.

I don't think trying to shift the blame or the focus will work, and we are never going to solve the problem of escalating health care costs by doing that. I think we all have a responsibility. So in that regard, let me ask you this.

Let's say 5 years from now there were no health mandate, 5 years from now, with more managed competition we still had an escalation of cost that was very considerable and there were still 30 million, 35 million Americans uninsured, two-thirds of them working or dependents, as is true today. Not as many, but say there were still 30, 35 million. Tell me conceptually—we have just a couple of minutes—what you think you would favor? What would be the next step?

Mr. MOTLEY. Wow. Mr. Levin, I think those of us in the business community who have been involved in the health care debate for a number of years now, and NFIB's involvement goes back to the late 1980s, realize the stakes that are involved in the statement that you just made, and the stakes that are involved in the suggestions that we made back in the late 1980s and early 1990s for certain types of changes that need to take place so that you can begin the march of coverage again.

If you take a look at the history of insurance coverage in this country, you will find that it really starts at around 1940, with about 1 percent of the population a year until you get into the mid-1980s, when you are up at about 86 percent, and now it has slipped back to about 85 percent. And our analysis of the reason it slipped back is we have had total uncontrollable costs.

And, frankly, I would not accuse any of the major manufacturers of ducking their responsibility, or their health care responsibilities, but I do think they have been part of the problem, though, with the way they have gone about addressing it because it has helped to drive the costs up.

Mr. LEVIN. But let's leave that because I think those who run the plans and have really tried to get hold of costs would love to challenge you. If I brought the benefits manager of Ford, Chrysler or smaller corporations, they would really quarrel.

But answer, if you would, 5 years from now, what would make sense if 5 years from now, after a further period of managed competition we still had 30, 35 million uninsured Americans? Tell me what is the next step? What would be agreeable to you?

Mr. MOTLEY. I am not sure I have a crystal ball to tell you what would happen. I could tell you that what we would do is we would be back in another very, very serious debate over Mr. McDermott's bill and I believe the bill which you are a cosponsor of.

Mr. LEVIN. Which bill is that?

Mr. MOTLEY. The single-payer.

Mr. LEVIN. No, no, I am not.

Mr. MOTLEY. You are not on the bill.

Mr. LEVIN. No. I am asking you conceptually where you go. I am not in favor of a single-payer system.

Mr. MOTLEY. But I do think that that would be the thing that we would have to come back and debate, however.

Mr. LEVIN. So there is nothing in-between, you think—

Mr. MOTLEY. I am not too sure the public would buy anything after we tried to make changes now and those changes did not work. I think the situation would be ripe for real serious discussion of whether the government should involve itself seriously in the running of the health care system.

Mr. LEVIN. Well, the red light is on. Your point of view is exactly what motivates a number of us. We think there is something worthy of discussion between kind of tinkering at the edges with the system and a single-payer system, and you kind of set up the extremes, I think.

Mr. MOTLEY. Well, unfortunately, the debate has led to that type of conclusion here today. But NFIB supports the Thomas-Chafee, and that is certainly something which is in-between. That has an individual mandate in it. It moves to universal coverage. I believe Senator Chafee is trying to draft it in a way that we move there as the savings are accrued from the changes that are made. There are serious political problems with that approach.

Our big disagreement is that the approach which the administration has chosen, we believe, trades health care security for job security, particularly in the small business sector, particularly on Main Street, and that is what we are trying to avoid.

And the individual mandate does two things: One, it says employers are not responsible, ultimately responsible for providing for everybody's health care who works in this country; and that, also, it is the most efficient way, in our opinion, to deliver the subsidies needed to those people who cannot afford to purchase health care.

I don't see why we have to set something up in-between. We just passed a significant expansion of the earned investment tax credit,

and one of the reasons, if I have listened to the debate over these years that people think that is good, is because it provides direct assistance to the people who need it in the most efficient way for the government. And I can't see providing—I can see we should provide health care assistance in that way to those people who need it. Why do it through the employer community? That is where I am coming from.

Mr. LEVIN. Because we have not been able to do it through the EITC, and nobody thinks by simply expanding it that we are going to dwindle dramatically the numbers who are not covered. And all the ramifications, including going to emergency rooms for their health care, are causing all of us to pay more.

Well, the red light is on. Thank you.

Mr. FORD [presiding]. The time of the gentleman has expired.

Let me thank all five panelists for testifying and responding to questions today. Thank you very much, Mr. Motley and Mr. Resnick, Mr. Butson, Mr. Woodhouse, and Mr. Melley. Thank you very much for your testimony.

Mr. FORD. The committee would like to call the next panel: Paul Merski, the Citizens for a Sound Economy, Fiscal Policy; Edward Delaney, the Coalition for Independent Contractors; Jeffrey Smedsrud, the executive vice president of Communications for Agriculture; also William B. Coleman, the American Academy of Family Physicians; along with Ronald Pollack, the Families U.S.A.'s executive director.

Mr. Chairman, I will turn it over to you. I was just getting the panel in place so we would not have to waste too much time.

Mr. Chairman, this is panel number three on the first sheet. No witnesses have been heard from. They have just been seated.

Mr. Jacobs, it is now in your hands.

Mr. JACOBS [presiding]. I call you chairman, so why don't you call me chairman; right?

Mr. FORD. Mr. Chairman, thank you very much.

Mr. JACOBS. I think it might be wise, since we are running way behind schedule today to remind you about the rules of the New York State Athletic Commission—go to a neutral corner and all that—but also the 5-minute rule has to be strictly enforced. I don't know if any of you have ever watched people on the floor—what? Three minutes. The 3-minute rule has to be strictly—it is a 1-minute rule for Members of Congress and the gavel comes down mid syllable.

So, we do not mean to be offensive or impolite or bad hosts, but it is the only way you can treat the people at the end of the line justly. So we can begin the testimony—

Mr. FORD. Mr. Chairman, I just want to make sure that that rule applies to the members on the podium here as well, because some have been going beyond that and we do have four other panels to come before the committee this afternoon.

Mr. JACOBS. Mr. Chairman, let's apply it to you but not to me.

Mr. FORD. Thank you.

Mr. JACOBS. We will go to the first person. Please, Mr. Coleman, would you proceed.

**STATEMENT OF WILLIAM H. COLEMAN, M.D., PH.D.,
PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS**

Dr. COLEMAN. Mr. Chairman, I am Bill Coleman. It is my privilege to serve as president of the American Academy of Family Physicians.

In 1992, the Academy became the first national physician organization to develop a plan for universal coverage that builds on our current system, the employer-based health insurance. You would not be surprised to hear that the employer mandate applicable to all businesses, including small firms, plays a central role in our strategy. First, it builds on the current system. Companies began offering and paying for health insurance to attract or retain workers during World War II. Today, a majority of the population obtains health insurance through the workplace, including 62 percent of small business employees. Moreover, 65 percent of the public endorses this approach, according to the recent Wall Street Journal/NBC poll. To me, that demonstrates that there is widespread support among Americans for an employer mandate.

Second, an employer mandate would reduce government expenditures for health care because the majority of the working poor would finally receive insurance coverage in the workplace rather than through the public assistance programs.

Also in this vein it is noted that an employer mandate would benefit firms now providing insurance for their workers by lifting the burden of cost shifting. Relieved of this burden, funds that otherwise would be diverted to health premiums may be rechanneled to employee wages, capital improvements, et cetera.

Fourth, enforcement should be less cumbersome via an employer mandate. Certainly an individual mandate could be put forward, but it will require the development of a whole new bureaucracy within the IRS to verify insurance coverage for more than 240 million citizens, one by one.

Finally, a word about small business. As you know, family physicians typically practice either in solo or in small groups, with fewer than 25 employees. My practice has five. For those of us providing insurance to our workers, this worthy benefit will consume at least 9 percent of payroll by the year 2000. With the employer mandate, the cost of providing coverage would be lowered to roughly 6.2 percent of payroll, and that sounds pretty good to me.

Distilled to its essence, the present debate forces us to ask whether health care that is always there will become an actual right of Americans or merely a theoretical right on paper. We submit to you that the employer mandate is the option most likely to guarantee that we achieve universal coverage that is fully financed while still maintaining our pluralistic system. To this end, we urge you to adopt an employer mandate as part of the reform bill this committee reports later this year.

I would like to thank you, Mr. Chairman, and at your discretion will be available for questions.

Mr. JACOBS. Thank you, Dr. Coleman.

[The prepared statement follows:]

**STATEMENT OF WILLIAM H. COLEMAN, M.D., PH.D.
PRESIDENT
AMERICAN ACADEMY OF FAMILY PHYSICIANS**

Mr. Chairman: I am William H. Coleman, M.D., Ph.D., and it is my honor to serve as President of the American Academy of Family Physicians. The Academy is the national medical specialty society representing 74,000 family physicians, family practice residents and medical students. It is my pleasure to appear before you today to share the views of our membership on the critical issue of an employer mandate as a means of achieving universal coverage in a reformed health care system.

Background

Since the mid-1980s, the issue of universal coverage of all individuals has been a pressing concern for the Academy. At that time, the impetus for national action was predominantly the growing number of uninsured persons and their inability to obtain appropriate medical care. Studies documented what family physicians have long known: that people who delay seeking medical care have higher morbidity and mortality rates and are significantly more costly to treat. Today this problem remains unresolved and has, in fact, worsened. Whereas in 1993 an estimated 37 million people were uninsured and, according to the *U.S. Industrial Outlook for 1994* released by the U.S. Department of Commerce, the nation spent 14.8 percent of the Gross Domestic Product on health care, today over 39 million people are uninsured and our nation is expected to spend at least 15.8 percent of the GDP on health care. This is a one-year jump from \$942.5 billion to more than \$1 trillion for the delivery of health care services and products.

As the Chair of the President's Council on Economic Advisors, Dr. Laura D'Andrea Tyson, reported to you last year, no other nation spends more than 10 percent of GDP for health care. Without reform, health care spending will continue spiraling upwards at astronomical rates. Indeed, using the Commerce Department report, it is estimated that absent system-wide reform, overall health care spending will rise at an average annual rate of 13.5 percent, creating an 88 percent increase in health care -- and leading to a doubling of health care spending by the year 2000 (to \$2.0 trillion). As the percentage of GDP diverted to health care has escalated, national attention on the problem of coverage has quite naturally shifted to an equally pressing anxiety over cost. The American Academy of Family Physicians shares these dual concerns.

Rx for Health: The Family Physicians' Access Plan

In response to our membership's concerns, in 1989 the Academy became the first national physician organization to develop a plan for universal coverage through a public/private effort, building on the current system of employer-based insurance. In April, 1992, the Academy released its revised and expanded plan for health reform, *Rx for Health: The Family Physicians' Access Plan*.

Permit me to briefly describe the key elements of this plan. *Rx for Health* calls for universal coverage of all Americans and a comprehensive set of health benefits emphasizing preventive services. The plan builds upon the present employer-based system of insurance and requires all employers, including small businesses, to provide insurance to their workers and their dependents. Under this approach employers pay a portion of the insurance premium, and employee cost sharing is based on income, with subsidies available for low-income workers.

A key element of the Academy's plan requires that each person have a personal physician who is a generalist -- that is, a practitioner of one of the primary care specialties (defined as family practice, general internal medicine, and general pediatrics). Increased cost sharing would be incurred if an individual chooses to obtain non-emergency subspecialty care without referral from his or her personal physician. *Rx for Health* includes specific strategies for moving the physician work force towards balance between generalists and specialists. Furthermore, the plan calls for improved quality of care by utilizing practice guidelines and malpractice reforms, including caps on non-economic damages. And, to address skyrocketing health care costs, the Academy's plan relies upon stringent cost control provisions such as the establishment of a national board with authority to set and enforce global spending targets. Enforcement is targeted specifically to those segments of the health care system responsible for inappropriate spending increases.

Rx for Health is the Academy's vision of health care reform. It has for some time now formed the basis of our discussions with members of the House and the Senate, and with the

Administration and other reform advocates. In short, the plan is the gold standard against which we will evaluate all reform proposals, and it includes the specific elements we will seek as you and your colleagues work for enactment this year of comprehensive reform that guarantees universal coverage.

As we strive to achieve this mutual goal, the Academy believes we must keep in mind the original catalyst for seeking reform -- the promise of affordable health insurance that includes comprehensive benefits for every individual. In the following statement I will comment at greater length about the role of an employer mandate in realizing this goal.

The Academy's Recommendations for Achieving Universal Coverage

Consistent with the objective of securing universal coverage that ensures appropriate, affordable health care, the Academy supports a combined private/public sector effort in which an employer mandate plays a central role. We believe that all employers should be required to provide health insurance that offers a comprehensive benefits plan, as defined by the federal government. Workers and their dependents should be covered by the plan. Small businesses are not exempt from the employer mandate under terms of the Academy blueprint. However, the Academy is sensitive to the varied resources of firms of all sizes and, for this reason, believes that the employer's contribution to health plans must be set to ensure a fair balance with the worker's portion of the insurance premium and cost sharing. Finally, the Academy wholeheartedly believes that federal standards for qualified employer group health plans should certify adequate coverage and access to comprehensive health care services necessary to prevent, diagnose, or treat injury and disease. Patient cost sharing for all plans should be designed to promote cost-conscious use of health services and discourage inappropriate use of expensive subspecialty services without referral from a personal physician.

As for publicly sponsored coverage, the other half of the equation, the Academy recommends in *Rx for Health* that each state establish a public program to replace Medicaid. This program would contract with private carriers to offer health insurance meeting the same standards required for employer sponsored plans. The state program would be available to small businesses and to individuals not otherwise covered by their employer or government health plans, such as Medicare. Financial assistance for premiums and cost sharing under the public plan would be based on income.

The Academy contends that enactment of these principles will result in an effective, straightforward national health policy under which all persons not otherwise covered today may at last be insured. Moreover, the Academy strongly believes that the adoption of an employer mandate as part of health system reform will help provide every American with genuine health security -- regardless of age, income, employment status or medical condition.

The Health Security Act and the Employer Mandate

As introduced, the *Health Security Act* stipulates the establishment of a nationwide employer mandate as the means of achieving universal coverage. Consistent with the principles of *Rx for Health*, the legislation specifies that the payment of insurance premiums will be split between employer and worker, the legislation specifying that 80 percent of the cost is contributed by the employer and 20 percent by the worker. Regardless of size, the contribution made by businesses towards employee health insurance premiums is capped at 7.9 percent of payroll. Firms with less than 75 workers have even lower caps, ranging from 3.5 percent to a maximum of 7.9 percent, depending on their average wage. These smaller businesses are eligible for subsidies to help them purchase health insurance.

The Benefits of an Employer Mandate

As stated above, attaining universal coverage is essential to health system reform and an employer mandate is the mechanism by which the Academy believes we are most likely to reach this goal. Unlike other competing suggestions, the employer mandate has specific strengths that make it a sound option for policy makers to adopt.

First, the employer mandate builds upon the current system. The system of employer-based health insurance became prevalent during World War II. Health insurance was offered and paid for by firms competing to attract and retain workers. After the war, the system continued growing as employer contributions for health insurance premiums became tax deductible, health insurance became a part of collective bargaining negotiations, and insurance companies found that costs for marketing, enrollment, and the collection of premiums were lower for groups than individuals. Today, workers themselves also favor employer-provided insurance because premium payments by employers are exempt from their gross taxable income, essentially raising their effective wage rate.

Right now, a majority of the population (roughly 150 million individuals) -- including 62 percent of small business employees -- get their health insurance through the work place. Strengthening employer responsibility by enactment of an employer mandate will extend this already widespread benefit system to those not now covered by it. Moreover, the idea of an employer mandate to achieve universal coverage is hardly a new one: the health reform plan that former-President Nixon submitted in 1971 also included an employer mandate.

Second, an employer mandate will reduce public expenditures. Today, the cost of treatment for uninsured individuals, including those who are employed, is shifted largely to those firms that provide coverage to their workers. This situation affects the competitiveness and flexibility of commerce and workers alike, contributing to problems such as job lock, industrial inefficiency, and a growing burden upon state and federal treasuries of wholly publicly-funded health care for poor and near-poor individuals. By contrast, universal coverage under an employer mandate would require smaller public subsidies for the poor and near-poor because it would ensure that the majority of low-income Americans receive their health insurance coverage through the work place rather than through public assistance programs. Alternative options for guaranteeing universal coverage such as broad-based new taxes or draconian, offsetting savings in other health programs are unlikely to attract majority support in the Congress, or among the public. However, a recent *Wall Street Journal/NBC* poll found 65 percent support among the public for the employer mandate approach.

Third, an employer mandate will benefit many employers currently funding plans and who are struggling to meet the escalating cost of health benefits for their workers. Employers who now provide health insurance benefits have been shown to cover more than their fair share of costs. On average, providers charge an extra 25 percent more to the private sector to cover the costs of the uninsured and underinsured. Under reform, this burden would be lifted. However, without reform, employers that now offer health benefits would see their premiums rise approximately 70 percent by the year 2000. But with enactment and implementation of reform that includes an employer mandate, such as the one in the *Health Security Act*, these premiums are expected to rise 29 percent -- less than half as much as under the status quo. In business terms this means that firms would divert about 8.2 percent of payroll to employee health benefits in the year 2000 without reform, but that this amount would drop to roughly 6.6 percent if Congress approves a reform law that includes the employer mandate. For family physicians, like other employers, this welcome relief means that businesses would at last be able to re-channel these funds that otherwise would have been spent on health care to wages, investment in new machinery and technology, and other quality improvement and competitive applications.

In the President's plan, as with *Rx for Health*, the employer mandate will benefit the majority of employers currently offering health insurance to their workers in the following ways:

- Caps on employer premiums as a percentage of payroll will create new limits on the exposure of all employers to increases in health care costs. Firms now struggling to balance skyrocketing health care costs with the need for capital and other productivity enhancements will get some overdue relief.
- Subsidies will, for the first time, be available to support small businesses in meeting the costs of health insurance.

- Employee cost sharing requirements will induce price sensitivity among consumers. Individuals will pay more if they choose more expensive health insurance coverage.

Finally, an employer mandate eases enforcement in a system of universal coverage. Premium collection and payment under an employer mandate will continue to be automatically deducted by employers from workers' paychecks, thereby building on the existing system. However, an individual mandate may require the Internal Revenue Service or some other entity (or combination of government entities) to verify the health insurance coverage of more than 240 million individuals. Achieving universal coverage will require some mechanism for enforcement that, in our view, is more easily implemented through employers than by monitoring each citizen separately.

A Word About Small Businesses

Family physicians typically practice solo or in small group arrangements. As small business owners and employees, we are very concerned about the potential for adverse economic consequences resulting from system-wide health reform. As stated earlier, that is why *Rx for Health* stipulates small businesses should be eligible to purchase health insurance from a state-established public program with the amount of the employer's contribution based on a reasonable percentage of payroll. This approach is similar to the one posited as part of the *Health Security Act*. As mentioned previously, a majority of the population (roughly 150 million individuals) -- including 62 percent of small business workers -- obtain their health insurance through their work place. The Academy believes that small employers now offering insurance or wishing to (including many family physicians), will benefit from health reform that includes an employer mandate.

It should be noted the Administration found that employers with less than 25 workers would by the year 2000 spend approximately 9 percent of payroll on health benefits in the absence of reform utilizing an employer mandate. With a mandate, however, it is projected that these same employers would spend only 6.4 percent of payroll for health benefits. As mentioned earlier, the *Health Security Act* also caps employer spending on health insurance at 7.9 percent of payroll regardless of the size of the firm. Businesses with less than 75 workers have even lower caps under the legislation, ranging from 3.5 percent of payroll to the full 7.9 percent, depending on their average wage level.

Although *Rx for Health* does not include specific recommendations regarding payroll caps, premium cost sharing levels or subsidy amounts, the plan explicitly backs the principle of fairness and sufficiency in the design and implementation of the employer mandate as it relates to all businesses -- and with a special sensitivity to the needs of small businesses. Accordingly, the Academy is eager to work with you and your colleagues to determine the appropriate payroll caps, subsidy amounts and cost sharing levels needed to make an employer mandate acceptable to the public and a workable component of universal coverage.

Conclusion

I deeply appreciate the opportunity to comment today on the employer mandate issue. In our view, this one issue is the keystone upon which hangs the remaining structure of a reformed, comprehensive health delivery system. Without an employer mandate it is unlikely that universal coverage and genuine health reform will be achievable while still maintaining our pluralistic system. To this end, the American Academy of Family Physicians is looking forward to working with you to attain the positive changes that we all seek. I would be pleased to answer any questions you may have at this time.

Mr. JACOBS. Mr. Merski.

**STATEMENT OF PAUL G. MERSKI, DIRECTOR, FISCAL POLICY,
CITIZENS FOR A SOUND ECONOMY**

Mr. MERSKI. Mr. Chairman and members of this committee, thank you for the opportunity to speak today. My name is Paul Merski. I am here on behalf of our 250,000 members. Like most Americans, our members are concerned with the rising cost of health care and would like to create greater access to the high quality care available in our country. Unfortunately, our detailed analysis of the Clinton administration's Health Security Act leaves little room for optimism that a Federal takeover of our health care system will result in improved quality at a lower cost.

President Clinton's proposed health care reform plan would impose tax increases and tax mandates that would easily eclipse the burden imposed under last year's \$248 billion record tax hike. If enacted as outlined, this health reform would launch the largest expansion of entitlements and Federal bureaucracy seen since the New Deal; and it would put government in control of the most personal decisions made by individuals.

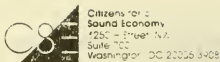
Ironically, the major reasons touted for undertaking reform in the first place was that the Nation was spending too much on health care and we could not afford it. With that, the Clinton administration is proposing \$300 billion in new health goodies in the first 5 years. And the financing of these increased expenditures is dubious, at best. The bulk of additional spending is claimed to be financed by future government savings in health care spending. Unfortunately, government savings has proven to be oxymoronic. Any savings in Medicare alone would have to be in addition to the \$56 billion already promised under the 1993 budget deal. When public pressure was on to find more spending cuts in the recent budget battle, lawmakers would not even allow another \$6 billion to be cut from Medicare over 5 years.

Despite the President's offer to subsidize small businesses to help pay for the mandate, even the smallest business, regardless of its income, would be forced to pay at least 3.5 percent of their payroll, and that amount is set to increase over time. This mandate is nothing more than a payroll tax that would discourage hiring, reduce wage growth, increase layoffs and reduce any profits of small businesses that now pay less for health coverage than the mandate would dictate. Worse yet, the new mandate would only compound the financial burden for many small businesses that are currently absorbing last year's 5-year income tax hike.

In just a few days, CBO is planning to release its scoring of the Clinton health reform plan. Hopefully, CBO will not succumb to the administration's pressure to ignore the employer mandate as a tax. It should call a tax a tax and keep the full cost of the Clinton health reform plan in the Federal budget.

Mr. JACOBS. You have concluded your 3 minutes. Maybe we can bring out more in the questioning.

[The prepared statement follows:]



Testimony on the Clinton Administration's Health Security Act H.R. 3600

By Paul G. Merski
Citizens for a Sound Economy

Before the
Committee on Ways and Means
U.S. House of Representatives

February 3, 1994

Mr. Chairman and Members of this committee, thank you for the opportunity to speak today before this committee. My name is Paul Merski, and I am here on behalf of the 250,000 members of Citizens for a Sound Economy (CSE), a non-profit, non-partisan citizens advocacy group based in Washington, D.C. Our members throughout the country have fought long and hard to help reduce federal deficit spending and to employ market-based solutions, not greater government intervention, to address our country's fiscal and economic problems.

Like most Americans, our members are concerned with the rising cost of health care and would like to create greater access to the high quality health care available in our country. Unfortunately, our detailed analysis of the Clinton administration's Health Security Act, H.R. 3600, leaves little room for optimism that a federal takeover of the health care system will result in improved quality at lower cost.

President Clinton's proposed health care reform would put government virtually in control of one-seventh of the country's gross domestic product and impose tax increases and tax mandates which would easily eclipse the burden imposed under last year's record \$248 billion hike. If enacted as outlined, his health reform plan would launch the largest expansion of entitlements and federal bureaucracy since the New Deal; and it would put government in control of the most personal decisions made by individuals.

Ironically, while the major reason touted for undertaking reform was that the nation is spending too much on health care, the Clinton proposal would add more than \$300 billion in health goodies to the tab just in the first five years. The financing of these increased expenditures is dubious at best.

President Clinton has outlined \$90 billion in new taxes largely from a major tax hike on cigarettes and a new corporate tax. However, the bulk of additional health spending is claimed to be financed by future government savings in health spending and by employer mandates. Unfortunately, government savings have proven to be oxymoronic.

Clinton claims \$189 billion in savings from Medicare and Medicaid by the year 2000, largely by decreasing reimbursements to doctors and hospitals. However, any savings in Medicare alone would have to be in addition to the \$56 billion already promised under the 1993 budget deal. When public pressure was on to find more spending cuts during this recent budget battle, lawmakers would not even allow another \$6 billion to be cut from Medicare over five years.

Clinton's plan to finance immediate health care spending increases with the promise of future savings is a recipe for fiscal disaster. While the federal government has a poor track record for frugality, it certainly has proven it can create massive, open-ended entitlement programs by initially concealing from taxpayers how much they will really cost and socking it to them later.

For example, the cost of Medicare today is more than five times the amount the government estimated it would cost at its start in 1966. If the federal government has failed to solve the financial problems of the current Medicare program it already oversees, how can we honestly trust it to handle health financing on a much larger scale?

While President Clinton maintains that he can finance his health reform plan without broad-based new tax increases, he simply does not consider the primary revenue source--an employer mandate--to be a tax. His mandate requires all employers to pay at least 80 percent of the average health plan offered by government-sponsored organizations for each employee; costs are to be capped at 7.9 percent of total payroll.

Despite the President's offer to subsidize small businesses to help pay for the mandate, even the smallest business, regardless of its income, would be forced to pay at least 3.5 percent of their payroll under the Clinton plan. And that amount is set to be increased over time.

This mandate is nothing more than a payroll tax that would discourage hiring, reduce wage growth, increase layoffs, and reduce any profits of small businesses that now pay less for health coverage than the new mandate would dictate. Worse yet, the new mandate would only compound the financial burden for many small businesses that are currently absorbing last year's income tax hikes. This tax hike is impacting hundreds of thousands of small businesses and their workers because most small businesses pay individual income taxes. Of all businesses in America, 80 percent are unincorporated and pay taxes as individuals.

After just pushing through the largest tax increase in history, it's little wonder why the administration has been pressuring the Congressional Budget Office (CBO) not to score its employer mandate as a tax and to keep it off the federal budget books.

In just a few days, CBO is planning to release its scoring of the Clinton health reform plan. Hopefully, it will not succumb to administration pressure and choose to ignore the precedents set under the budgeting of the Social Security and Unemployment systems. They should call a tax a tax and keep the full cost of Clinton's health reform plan in the federal budget.

In order to better assess the potential economic impact of Clinton's health reform plan, CSE has commissioned the econometric forecasting firm of DRI/McGraw-Hill to quantify the national macroeconomic effects of H.R. 3600. While the final results of this comprehensive study will be completed and released later this month, I am glad to be able to share some of the preliminary findings with the committee concerning the impact of the employer mandate. I will provide the committee with the final study as soon as it is completed.

Currently, less than two-thirds of employers offer health insurance coverage to their employees. H.R. 3600 would require that all employers contribute 80 percent of the average insurance premium of the government-mandated benefit package for all employees. This requirement will increase health benefits for some (mostly small) employers and decrease such costs for other

(mostly large) employers, but will increase such costs in the aggregate.

According to the DRI study's preliminary findings, when an employer mandate is used to partially finance universal coverage, employment gains due to universal coverage are more than offset by the employment losses associated with the mandate. Since a mandate is really a tax, it increases employers' cost of doing business. Employers will attempt to pass the cost increase through to consumers in the form of higher prices (lower real wages). Consumers respond to the higher prices by cutting back on real spending for medical and non-medical goods and services, resulting in a negative impact on employment and GDP.

In the year 2000 the combined impact of universal coverage and the employer mandate would result in hundreds-of-thousands of lost jobs, an increased deficit and lower GDP growth. The additional taxes proposed to pay for universal coverage (tobacco tax, corporate assessment, adjustment to flexible spending accounts, and changes in medical expense deductions), would exacerbate the negative employment and income effects caused by the employer mandate, however, the deficit would be lower due to the increased tax revenue.

Perhaps the worst aspect of the Clinton plan is that, despite the economic cost, it would actually make the health care problem worse. By expanding government health subsidies and mandating that employers finance government-dictated health insurance, the Clinton plan would solidify and worsen the main cost problem in the current system: third-party payments.

Average Americans aren't the consumers in the health care and health insurance markets because they usually aren't the ones paying the bills. This third-party system exists because the tax system favors employers purchasing health insurance over individuals purchasing insurance or medical services directly.

Individuals are rarely aware of the full cost of their health spending actions because employers, and other third-parties are handling the tab. Generally, only 20 cents of every dollar of health care spending comes out of pocket. Third-party payments initially reduce the financial burden on patients and provide few incentives to hold down the use of services and the prices charged by providers.

In 1965, 80 percent of medical care spending was paid out of pocket. In 1966, the Medicare and Medicaid programs were passed. As a result of tremendous growth in those programs, and the spread of low-deductible private insurance, out-of-pocket spending dropped to only 15 percent of total health spending by 1991. In order to promote cost containment and thus greater access to health services, individuals must evaluate services, at least in part, on the basis of price. Unfortunately, under the Clinton plan, the absence of individual cost-consciousness will continue to plague our health care system.

Proposed cost containment measures in the Clinton plan will do little to change this basic flaw in the current health care system. Limiting choices, and capping spending only further undermine consumers' efforts to seek out the best value for their health care dollar.

Rather than a government takeover of our health care system, as President Clinton has proposed, individual consumers must be put in control of their health care decisions. The answer to controlling costs and increasing access lies in enhancing market forces, through tax reform to eliminate the bias against individual insurance purchases. A good start in this direction would be to allow health care consumers to purchase tax-free "Medical Savings Accounts," similar to today's Individual

Retirement Accounts, through which they can save for small bills and pay them directly; and thereby giving them more control over their own medical care.

Consumers using individual Medical Savings Accounts who become temporarily unemployed or change jobs would not lose access to medical services. Since the majority of uninsured Americans are without insurance for less than five months, this portability would greatly reduce the number of consumers who are without insurance. As the number of uninsured falls, hospitals and doctors would have fewer unpaid bills to shift onto other patients and taxpayers, resulting in reduced health care costs.

I thank the committee for the opportunity to testify today and would be glad to answer any questions you may have.

Mr. JACOBS. Mr. Delaney.

**STATEMENT OF EDWARD N. DELANEY, COUNSEL, COALITION
FOR INDEPENDENT CONTRACTORS**

Mr. DELANEY. I am Edward Delaney of Edward N. Delaney & Associates, and I appear today on behalf of the Coalition for Independent Contractors.

We are seriously concerned about the employer mandates contained in the Health Security Act largely because it would impose heavy administrative burdens on small business independent contractors; it would hinder the natural growth of many small independent contractor businesses from sole proprietorships to small businesses. It would exacerbate the government's disdain for small business independent contractors reflected by the provisions that are in HSA allegedly to eliminate abuses that would come about from switching and some other matters.

The coalition is concerned that the Treasury Department might define, as it is granted the authority to under subtitle C, the term "employee" so broadly that entrepreneurs could not qualify to do business as independent contractors.

The coalition is concerned that the information reporting burden that the Health Security Act would impose on small businesses and independent contractors is very substantial. More importantly, we are concerned about the draconian civil penalties that apply in case of a failure to provide all the information requested. Small business generally is not faced with that kind of a penalty.

The HSA employer mandate provision would increase substantially the cost and burden of hiring new employees, which could result in businesses seeking ways to avoid hiring employees in order to avoid such consequences. Small business and independent contractor status is the growing area for employment in this country. As a result of the downsizing by large businesses, many former employees are going into business in an independent contractor status. HSA would limit the ability to do that.

The coalition is concerned if HSA were enacted that government would view independent contractors as an artifice used by businesses in order to become eligible for small employee subsidies. We have heard some of those stories this morning and again this afternoon.

The enactment of the HSA would likely result in the government contending that businesses that use independent contractors who reside in different geographic areas are treating them as such solely to avoid the withholding and related administrative requirements that would apply under HSA with respect to workers if they had been hired as employees.

The employer mandate would create, we believe, a hostile regulatory environment for the self-employed. It would, as we say, impose unnecessary burdens on small business and have the effect of hindering the natural growth of many independent contractors and small business employers. We, therefore, are in opposition to that provision.

Mr. JACOBS. Thank you.

[The prepared statement follows:]

**STATEMENT OF EDWARD N. DELANEY
COUNSEL
COALITION FOR INDEPENDENT CONTRACTORS**

I am Edward N. Delaney of Edward N. Delaney & Associates, Chartered, Washington, D.C., and I am submitting these comments today on behalf of The Coalition For Independent Contractors (the "Coalition").

The Coalition submits this statement on behalf of the American Pulpwood Association, the Associated Builders and Contractors and the National Association of Independent Insurers.

For the reasons set forth below, the Coalition is seriously concerned with the concept of pursuing major health care reform by means of an employer mandate.

I. Overview

The Coalition is concerned about the employer mandate concept because, as implemented by the Health Security Act ("HSA"), the mandate:

- results in the HSA containing onerous provisions allegedly included to reduce or eliminate abuse of the employer mandate provisions and related government subsidies;
- would impose a heavy administrative burden on small business independent contractors;
- would hinder the natural growth of many independent contractor businesses from sole proprietorships to small business employers; and
- would exacerbate the government's disdain for small business independent contractors.

Because of the foregoing concerns, the Coalition urges that consideration be given to achieving changes in the health system through a means other than an employer mandate.

II. HSA Provisions Would Empower The Government To Limit An Individual's Opportunity To Work As An Independent Contractor

In order to reduce or eliminate a business's ability to structure its relationships with service providers in ways that would minimize its costs and burdens under the new health care system, the HSA would dramatically alter the rules for determining who is, and who is not, an independent contractor.

The HSA would authorize the Treasury Department to draft new rules for determining "employee" status. Because the power to devise new rules would reside with an administrative agency, changes to the definition could be made without input from the Congress. What is more, because of the relatively open-ended authority that the HSA would provide the Treasury Department, taxpayers would face a near-insuperable burden in obtaining judicial relief if the Treasury Department were to devise an overly expansive definition of the term "employee."

The Coalition is concerned that the Treasury Department might define the term "employee" so broadly that entrepreneurs seeking to establish their own business would be unable to achieve or retain independent contractor status. This concern is exacerbated by the discussion in Section IV of how the HSA effectively casts independent contractors as a source of higher costs and higher administrative burdens within the context of health care reform. The small business independent contractor represents a very important aspect of the economy of this country, particularly in light of the high level of "downsizings" being instituted by large businesses.

III. Employer Mandate Would Impose A Heavy Administrative Burden On Small Business Independent Contractors

The employer mandate contained in the HSA would require an employer to obtain from its employees, and provide to the appropriate health care entity, all the information concerning its employees that is needed to ensure that the appropriate level of health care coverage is provided and to determine the correct amount of premium owed for such coverage. The HSA would require independent contractors, who are treated under the HSA as their own employer, to

provide the requisite information with respect to themselves. The HSA imposes a civil monetary penalty of up to \$10,000 for failing to provide the information requested.

The Coalition is concerned that the information reporting burden that the HSA would impose on small business independent contractors would be substantial. More importantly, the Coalition is concerned about the draconian civil monetary penalty that can apply in the case of a failure to provide all of the information requested. The Coalition believes that these rules are so stringent because they are intended primarily to ensure that third-party employers comply with all the information reporting responsibilities that the HSA would require with respect to their employees. Hence, the Coalition believes that in the absence of an employer mandate, less onerous information reporting rules would be appropriate.

IV. Employer Mandate Would Hinder The Natural Growth Of Small Business

The specter of complying with all applicable employment laws and regulations, all federal and state employment tax and income tax withholding and depositing rules and regulations, and all the other sundry statutory and regulatory rules associated with the hiring of the first employee - under existing law - can be frightening. The HSA employer mandate provisions would only add to such fears.

The HSA would require an employer to obtain and provide to the appropriate health care entities all information needed to provide appropriate health care coverage for its employees, to collect the employee share of health care premiums, and to remit the same to the appropriate health alliance. In addition, the employer itself would be required to pay a substantial portion of the health care premiums with respect to its employees.

In the case of an employer with employees residing in different regional alliance areas, the employer could be required under the HSA to make payments to, and comply with information reporting demands of, each regional alliance covering an area in which any of its employees reside.

The foregoing responsibilities would be imposed on employers because of the HSA requirement that employees obtain health care coverage through their respective employer. Hence, the employer burdens are a direct consequence of the employer mandate approach.

The Coalition is concerned that the HSA employer mandate provisions would increase substantially the costs and burdens of hiring an employee, which could result in businesses seeking ways to avoid hiring employees in order to avoid such consequences. The Coalition believes the HSA would seriously hinder the otherwise natural growth of many one-person proprietorships into small business employers. It is submitted that such a stifling of small business expansion would be an undesirable consequence of health care reform.

V. Employer Mandate Would Exacerbate The Government's Disdain For Small Business Independent Contractors

Many HSA provisions that pertain to the employer mandate would create government hostility towards small business independent contractors.

In order to enhance the attractiveness of an employer mandate to small businesses, the HSA contains a small business subsidy which would ensure that an employer's financial obligation with respect to its employees' health care coverage did not exceed a percentage of wages paid for the year. The subsidy would limit a qualifying small employer's cost for a year to a range of from 3.5% to 7.9% of wages paid. To qualify for the federal subsidy, an employer could not employ more than 75 full-time equivalent employees, and the average wages paid to its employees could not exceed prescribed levels. Employers with fewer full-time equivalent employees who earn lower average wages would be eligible for caps at lower levels.

Because of the substantial cost to taxpayers of providing the small employer subsidy, and the alleged substantial benefit to small businesses that qualify for the subsidy, enactment of the HSA would result in the government being concerned about businesses seeking to structure their operations in ways that would maximize their potential government subsidy. One means by which a business might restructure its operation would be to classify predominantly high wage

employees as independent contractors, thereby reducing the number of its employees and reducing its average wage level.

The Coalition is concerned that if the HSA were enacted, the government would view independent contractors as an artifice that is used by businesses in order to become eligible for the small employer subsidy.

The HSA would also require employers to withhold the employee portion of health care premiums and remit the amount withheld to the appropriate health alliance. As noted above, a business with geographically dispersed employees could conceivably owe premium payments to several different health alliances. Consequently, the administrative burden of complying with this requirement could be substantial for employers with geographically dispersed employees.

The Coalition is concerned that enactment of the HSA would result in the government contending that businesses that use independent contractors who reside in different geographic areas are treating them as such solely to avoid the withholding and related administrative requirements that would apply with respect to the workers if they had been hired as employees.

Furthermore, since independent contractors under the HSA would effectively "self-withhold" their health care premiums, the existence of independent contractors would increase the burden the government bears in administering the health care system. Rather than receiving bundled premium payments for hundreds of workers from one employer, a substantial number of individual premium payments would be received.

The Coalition is concerned that the government might define the term "employee" as expansively as possible, in order to mitigate its administrative burden.

The HSA would subject employers to audits by regional alliances, to assure that employer payments for a year were of the correct amount. Since an independent contractor is treated as an employer under the HSA, independent contractors would also be subject to audit.

The Coalition is concerned that the government would seek a reduction in the number of independent contractors in order to reduce the number of health premium audits that would be necessary.

The foregoing provides only a few examples of why the Coalition fears that the employer mandate could translate into overly aggressive enforcement efforts to reduce the number of independent contractors. Such a result - as experience has shown - would create an intolerable business and financial environment for small business independent contractors.

VI. Conclusion

While global competitive forces are placing heavy strains on United States businesses struggling to compete, the Coalition is very concerned about the impact of an employer mandate.

The employer mandate would create a hostile regulatory environment for the self-employed, it would impose unnecessary administrative burdens on small business, and have the effect of hindering the natural growth of many independent contractors into small business employers. For these reasons, the Coalition urges that consideration be given to seeking health care changes through some means other than an employer mandate.

Respectfully submitted,

The Coalition For Independent Contractors
Edward N. Delaney
Russell A. Hollrah
Edward N. Delaney & Associates, Chartered
Counsel

Mr. JACOBS. Mr. Smedsrud.

**STATEMENT OF JEFFREY SMEDSRUD, EXECUTIVE VICE
PRESIDENT, COMMUNICATING FOR AGRICULTURE**

Mr. SMEDSRUD. Yes, Mr. Chairman, my name is Jeffrey Smedsrud. I am executive vice president of Communicating for Agriculture. Our organization has been very active in health reform issues for many years and worked to create a number of programs around the country for those denied insurance.

We support health reform and guaranteed access, but we have doubts that an employer mandate as written would benefit family farmers. Agriculture is very diverse, and an employer mandate impacts agriculture in different ways.

Our group represents family farmers in America whose source of income is the farms they own and manage. Almost all hire part-time help, and some hire seasonal labor. But rarely, rarely do they ever have more than five workers full or part-time. According to our surveys of these farmers, 93 percent of them are insured.

For family farmers with hired help, an employer mandate, frankly, will either mean the help gets paid less, or the farm family keeps less. Family farmers cannot arbitrarily raise their prices. As such, any cost associated with paying a business share is born directly by the farm family itself.

It is difficult to determine for farm families the appropriate share to be paid by farmers, especially when you look at its patterns in farms among rural America. Are the hired hands independent contractors and themselves self-employed? Or are they employees?

We also have asked farmers about their reaction to an employer mandate. We commissioned an independent research firm that found about 64 percent oppose the notion of an employer mandate.

But let me say that for some self-employed farmers without employees a mandate, if capped at 7.9 percent for the employer's share, plus the individual portion, would in fact reduce insurance costs. This is especially true for older farmers and for farmers who employ family members. Young farmers and farmers whose spouses earn relatively high, self-employed income would pay more. So there are clearly winners and losers in agriculture and there is indeed also wide fluctuations in income amongst farmers.

But what of the other sectors of agriculture? The processing companies and agribusiness firms, many of which have very high rates of uninsured among their workers? A mandate significantly increases the numbers of workers with insurance coverage, but in most instances it would be likely paid directly by the workers themselves.

In summary, an employer mandate while having the result of increasing the number of rural Americans with insurance may have an offsetting economic impact by lowering the net farm family income. It opens up difficult questions regarding the complexities of employment categorization. We believe there are other remedies and very briefly we think a fair tax treatment needs to be immediately done, and if there is to be a mandate, we believe that it is best put on the individuals instead of the very, very small employer, particularly agriculture, which has such high and wide fluctuations of income.

My last point is that if you look at seasonal and migratory workers, they have very, very high percentages of uninsuredness. An employer mandate is going to do nothing to solve a very serious problem. Thank you.

Mr. JACOBS. Thank you.

[The prepared statement follows:]

**STATEMENT OF JEFFREY SMEDSRUD
EXECUTIVE VICE PRESIDENT
COMMUNICATING FOR AGRICULTURE**

Mr. Chairman and members of the Committee. My name is Jeffrey Smedsrud, I am executive vice president of Communicating for Agriculture (CA). I am here today on behalf of CA, which is a national non-profit association with farmer and rancher members in 48 states. One of our key concerns is the impact the proposed employer mandate would have on agriculture.

It is appropriate to begin with a series of definitions about agriculture.

Our group represents many family farmers. The principal source of income for these people is the farm they own and manage. Almost all hire part-time help and some hire occasional, seasonal labor — but rarely do they have more than five workers — full- or part-time. According to our surveys, about 93 % of these farmers are insured.

There is also a sector of agriculture that includes agribusiness industries and processing companies and larger "farm" units. Some of these businesses have 100 or more employees, wages paid to many of these workers are often less than \$30,000, and about 30 % of these firms do not provide health insurance as an employee benefit.

Last, there are seasonal and migrant farm workers. They are paid low wages. They have difficulty getting insurance. And — though difficult to estimate — perhaps more than 50 % of these workers are uninsured.

Family farmers themselves are often insured. But workers of large agricultural operations are one of the sectors of the U.S. economy with the largest number of uninsureds.

An employer mandate impacts each of these sectors of agriculture, but in different ways.

For family farmers, an employer mandate adds to paperwork and increases costs for the farmer. Because most farmers are self-employed, he or she would pay the proposed 7.9 % mandated employer health insurance premium, plus the employee's share. Often the spouse, if he or she works, is also self-employed. Thus, a farm couple could be faced with having to 'take a double hit twice'. Family farmers cannot arbitrarily raise their prices. As such, any costs associated with paying the business' share — whether 8 % or 6 % or maybe, someday, 10 % — is borne directly by the farm family, which has no mechanism for passing on these costs.

For family farmers with hired help, an employer mandate will either mean the help gets paid less, or the farm family keeps less.

For small farm operations, it will be difficult to determine the appropriate share to be paid by the farmer, especially when part-time workers are hired. For example, are the hired hands independent contractors — and thus, themselves, self-employed? Or are they employees?

Attempts to re-classify independent contractors as employees, and thus make the farmer responsible not only for the health premiums but also for FICA, would be an extreme hardship on family farmers, and also on the rural communities in America's heartland that are supported by a diversified family-based agriculture.

What do farmers themselves think of an employer mandate?

Communicating for Agriculture commissioned an independent professional research firm to poll a representative sample of 400 farmers nationwide to ask them about employer mandates and health reform. A few highlights:

Only 19 % said they thought employers should be asked to pay for an employee's health insurance. Sixty-four percent said no. Others could support the concept if only full-time employees were included or if other changes were made.

For the self-employed farmer, without employees, a mandate — if capped at 7.9 % for the employer share, plus 1.9% for the individual portion — would result in reduced insurance costs for some farmers. This is especially true for older farmers. However, younger farmers would probably pay more. Farmers who employ family members would pay less; farmers whose spouse earns a relatively high, self-employed income would pay more. There are winners and losers.

The illustrations made on behalf of family farmers would also hold true for the thousands of small, mainly self-employed agricultural support industries — fertilizer salesmen, crop dusters, veterinarians, mechanics and others.

But what of the other sectors of agriculture? The processing companies and agribusiness firms who employ many rural Americans pay them as well as they can, but do not always pay for their insurance. An employer mandate will significantly increase the number of workers with insurance coverage — and probably provide better coverage than some now have — but in many industries it will likely be paid for directly by the workers themselves in terms of lower wages and reduced benefits. In fact, economists estimate that upwards of 80 % of the cost of the mandate will be covered by employers by reducing wages and eliminating jobs, especially in stagnant industries with lower wages. Higher food prices could be a result — because unlike farmers, agri-processing companies do have some control over the pricing of their products.

Finally, what of the seasonal workers who are, for the most part, uninsured and almost always paid a low wage? Seasonal workers are now categorized as independent contractors and in most instances do not meet the complex employment thresholds to be covered under an employer plan. It will obviously be in their best interest to be considered an employee — they would then pay 1.9 % — and not as a contractor.

But attempting to classify seasonal workers as employees — in order to get them insurance they can afford — opens a “Pandora’s box” of other issues, including workers’ compensation, FICA, and other tax and regulatory matters.

The proposed mandate has the potential to cause major disruptions and conflicts in the usual hiring and labor practices for farmers and ranchers. Farmers today, like most small businesses, are crying out for relief from the nearly overwhelming amount of paperwork they are required to do. The proposed health insurance employer mandate could further aggravate this situation, and lead to difficulties for many producers in managing their operations because they could no longer afford hired help.

Please understand, our members and farmers and ranchers throughout the country have great concern and compassion for people who don’t have health insurance or are under insured. Many go to great effort and expense to help provide coverage for employees they may have, and they would like to do more. Eighty percent is too much of a cost. The changes we need to make are to rein in costs, and make the health insurance system simpler and more manageable for the self-employed and small employers.

In summary, an employer mandate, while having the result of increasing the number of rural Americans with insurance, may have offsetting economic impacts by lowering the net income of farm families and very small rural businesses. In addition, it opens up difficult issues regarding the correct employment categorization of farm workers. Thus, it strikes us that there may be better remedies available to make insurance affordable, both for farmers and for employees in agricultural industries, especially migrant farm workers.

Such remedies would include fair tax treatment for those who pay their own insurance premiums, tax credits for the working poor, and increased efforts to encourage pooling arrangements, on a voluntary basis, to reduce costs and insurance reforms that improve access and portability of coverage.

CA is a member of a joint working group of rural and commodity associations and groups examining how health care reform may affect rural America. Other members include the National Cattlemen’s Association, National Corn Growers Association, American Soybean Association, National Pork Producers Association, National Association of Wheat Growers, National Grange, National Milk Producers Federation, National Barley Growers Association, and the American Veterinary Medical Association.

Thank you.

Mr. JACOBS. Ms. Torda.

STATEMENT OF RONALD F. POLLACK, EXECUTIVE DIRECTOR, FAMILIES USA FOUNDATION, AS PRESENTED BY PHYLLIS TORDA, DIRECTOR, HEALTH AND SOCIAL POLICY, FAMILIES USA FOUNDATION

Ms. TORDA. Our director, Ron Pollack, is sorry he could not make it today. He had an emergency commitment. I am director of health policy for Families USA. Families USA is a national nonprofit organization that represents consumers on health and long-term care issues. We strongly support the President's goal and his specific proposal to achieve universal and comprehensive coverage for all Americans. We believe that American families are looking to health reform to provide them with the security of knowing they will always have comprehensive health benefits they can never lose.

There are three possible ways of achieving universal coverage—through a single-payer system, through an individual mandate, or through an employer mandate. Families USA has concluded that an employer mandate offers the fairest and most practical way of achieving universal coverage. Let me briefly explain why.

A single-payer approach would certainly provide all Americans with comprehensive guaranteed health benefits, but this approach would require major tax changes and have redistributive effects. For these reasons, we see this approach as less politically viable.

Another way in theory to reach the goal of universal coverage is the individual mandate. But can coverage under this scheme be affordable? In order to make coverage affordable for individuals, significant subsidies would have to accompany such a mandate. Most businesses that do not provide coverage are small businesses, many with low-wage workers. These are the individuals that can least afford to pay the entire premium for coverage. For example, a worker making \$12,000 a year would have to pay a quarter to a third of their income for health insurance. Without an employer contribution, in order to make coverage affordable, taxpayers would have to foot the entire cost of adequate subsidies.

An employer mandate, which requires that all employers and employees contribute toward their coverage is a fair and practical way to achieve the goal of universal coverage. This is the alternative that is least disruptive to the current system. This approach levels the playing field. Most employers are contributing now. Additionally, many employers are paying for the coverage of working spouses whose employers do not want to pay their fair share. Employers who now pay coverage must also foot the bill for uncompensated care. This approach requires a smaller tax burden than either an individual mandate or the single-payer model.

Finally, recent polling indicates that Americans are comfortable with building on the current employer-based system with an employer mandate. A frequently heard criticism is that jobs will be lost with an employer mandate. Yet under the President's health reform bill significant subsidies are given to small businesses and individuals to make this affordable.

Thank you.

Mr. JACOBS. Thank you.

[The prepared statement and attachment follow.]

Testimony by
 Ronald F. Pollack
 Executive Director
 Families USA Foundation before
 The WAYS AND MEANS COMMITTEE

10:30 a.m. 1100 LONGWORTH HOB
 U.S. HOUSE OF REPRESENTATIVES
 FEBRUARY 3, 1994

Mr. Chairman and Members of the Committee:

Good morning. Thank you for allowing me to testify before you today. Families USA is a national nonprofit organization that represents consumers on health and long term care issues. We strongly support the President's goal, and his specific proposal, to achieve universal and comprehensive coverage for all Americans. We believe that the current crisis state of our health care system can and must be fixed. I will focus my testimony today on why an employer mandate is the most effective and practical way to achieve universal coverage. I have attached to my testimony our most recent report which analyzes the impact of three prominent bills which are before this committee on ten American families. I hope you find it informative.

Is there a health care crisis?: Millions Are Losing Health Insurance

The goal of health care reform must be to assure every person in America that he or she will never lose his or her health insurance, no matter what. Attached is a copy of a report we released earlier this year that found that over 2.25 million people lose their health insurance each month. In the state of Illinois, for example, 90,000 people lose their health insurance each month. Most of the people who lose their coverage will lack insurance for less than five months, yet a significant portion will lack insurance for six months or more. During this time, families are at grave financial risk if a member becomes sick or injured. Over the course of a year, nearly one out of every four Americans lose or lack health insurance for part of the year.

People lose their health insurance for a variety of reasons. Many people, for example, lose their coverage because they lose their jobs, their employer's policy is canceled, or they change jobs. While most of them regain coverage in the future, some never regain their coverage and others will be subject to limitations on coverage for pre-existing conditions.

American families with a member who has chronic health condition can easily find themselves in the position of being unable to change jobs because the family is dependent on the health insurance obtained through one family member's job. One in five (19%) workers report that they or a family member are locked in their jobs because new work offers limited or no health insurance.

Achieving Universal Coverage

We believe that no one should lose or lack high-quality health care coverage. Health security must be assured for all Americans. Several alternatives to reform the health care system have been proposed by Members of Congress. They do not all reach the goal of universal coverage. Three basic approaches could result in universal coverage: an individual mandate, a single payor system, and an employer mandate.

Families USA has concluded that the best way to reach universal coverage is through an employer mandate. Compared to all other solutions, an employer mandate builds on our employer-based insurance system and would be the least disruptive. It would level the playing field among different employers, most of whom provide such coverage today. It would also eliminate the large, unpredictable and inequitable cost shifts that employers bear

today for the uninsured workers of other employers. It is a practical and fair way to achieve our goal.

I would like to further explain why an employer mandate is the best solution for our current crisis.

The status quo

Today, most businesses provide insurance for their employees. Yet, small business owners, employees and their families encounter great difficulties obtaining affordable health insurance.

Small groups generally must pay ten to forty percent more for health insurance than large groups. Those who would purchase health insurance as individuals or as part of a small business group face another formidable barrier to health coverage because of medical underwriting practices. Medical underwriting is the process by which an insurer evaluates the health history and the potential for poor health status and high claims for an individual or group. Based on current underwriting practices, approximately 15 percent of all small businesses are ineligible for insurance or eligible only for restricted coverage.

Some Members argue that changing the rules by which businesses purchase coverage is sufficient reform. In 1992, we prepared a study of insurance market reforms that concluded that changes in insurance company rules, in isolation, would mean that many more businesses would see their premiums rise as would see their premiums go down. Market reforms only might result in increased access for some minority of people who are without coverage but the premiums for most businesses would continue to soar and even be exacerbated. The major problems of eliminating the extra costs for uncompensated care and out of control premiums would continue unabated for all businesses and millions of people would continue to lack coverage. While we agree that health care reform must change the rules by which insurance companies operate, insurance reform without comprehensive reform will not work.

Individual Mandate

One way, in theory, to reach the goal of universal coverage is the individual mandate. Under this scheme, all individuals, not employers, are required to purchase their own health insurance. Employers could be required to offer coverage, but would not be required to pay for any part of the premium.

But, can coverage under this scheme be affordable? In order to make coverage affordable for individuals significant subsidies would have to accompany such a mandate. We know that most businesses that do not provide coverage are small businesses, many with low-wage workers. Without employers contributing a portion of the premium cost, the entire burden becomes the individual's. These are the individuals that can least afford to pay the entire premium for coverage. For example, a worker making \$12,000 a year would have to pay a quarter to a third of his entire income for health insurance. Without an employer contribution, in order to make the coverage affordable, taxpayers will have to foot the entire cost of adequate subsidies.

Additionally, employers that now provide financial help for coverage may decide to drop their contribution if federal subsidies are available for individuals. This would, in turn, increase the total funds needed to make the individual mandate affordable.

Federal government costs would also increase as a result of increased administrative responsibilities. An individual mandate would necessitate an enlarged bureaucracy to keep track of each individual's coverage status.

Given the current budget constraints this country faces, an individual mandate would create a significant financial burden that the taxpayers and Congress are not likely to embrace.

Single Payor

A single payor, Canadian-style system has been touted by many as the most simple, straightforward approach to ensuring universal coverage. For Canadians to receive care, they must present their national card to doctors, who bill their provincial governments; the provinces fund hospitals directly under set budgets. All this is paid for from significant provincial and federal revenues collected from citizens and employers.

Clearly, the goal of providing health security for all Americans would be reached if this model were enacted in this country. The political, as opposed to the substantive, practicality of this approach, however, is questionable. The wholesale redistributive changes, as well as the need for unpopular tax increases makes the tax-financed option less politically viable.

Employer and Employee Mandate

It is clear that an employer mandate which requires all employers and employees to contribute toward their coverage is a fair and practical way to reach the goal of universal coverage.

The reasons we support an employer mandate are as follows:

- It is the alternative that is least disruptive to the current system. Since most employers now provide coverage, an employer mandate would help fill in the gaps for working families. It would not unravel a system that does work for many Americans.
- It levels the playing field. Most employers are contributing toward their employees' coverage now. Additionally, many employers are paying for the coverage of working spouses whose employers do not want to pay their fair share. Employers who pay for coverage also foot the bill for uncompensated care of those people who are uninsured and who have jobs that do not provide coverage.
- It requires a smaller tax burden than either an individual mandate which leaves the whole burden of the cost on the individual and the taxpayers or the single payor model which requires massive changes in the collection and distribution of tax dollars.
- Recent polling seems to indicate that Americans are comfortable with building on the current employer-based system by imposing an employer mandate.

We recognize that some employers and employees will need subsidies to help meet their financial obligations. Small businesses and low-income individuals specifically will need such assistance. The federal government, we believe, should provide these subsidies, which would total far less than under an individual mandate.

A frequently heard criticism that is made of the employer mandate is that jobs will be lost if this system is imposed. Yet, under the President's health reform bill, significant subsidies are given to small businesses (and individuals) that will need financial assistance to meet their obligations. For the worker that makes \$12,000, for example, the employer contribution equals a \$.20 an hour increase. Increases in the minimum wage at even higher levels have never produced the doom and gloom scenarios of job loss that were predicted. Moreover, for the businesses that already pay for health care coverage, they will receive relief because they no longer will need to subsidize the costs of uncompensated care.

Conclusion

This year we must enact comprehensive health care reform that will guarantee that families will never lose their health insurance. The goal is within our reach. Requiring employers and employees to contribute to coverage can get us to that goal. We look forward to working with you as we complete this task.

Losing Health Insurance

Every month more than two million Americans lose their health insurance, and millions more lie awake at night worrying that they might be next. During any period of time Americans must go without health insurance, they are in a position similar to skidding on an icy mountain road. It may be over quickly. They will probably survive it, but their family may go over the cliff.

Tom L. suffered a heart attack while he was between jobs. His surgery left him with a \$25,000 bill to pay out-of-pocket.

Kathleen and Don N. lost their health insurance when Don lost his job. Shortly thereafter, Kathleen was diagnosed with cancer. To pay for her cancer treatment, they ultimately had to sell their house and move to a small apartment.

This Families USA special report presents the first state-by-state estimates of the number of Americans who each month lose their health insurance and the peace of mind that they will be able to take care of their families' health care needs.

♦ Nationally, 2.25 million Americans a month lose their health insurance.

♦ The following states have the largest numbers of persons who lose their insurance each month:

California (306,000)	Michigan (76,000)
Texas (173,000)	North Carolina (64,000)
New York (130,000)	Georgia (62,000)
Florida (113,000)	Virginia (55,000)
Illinois (90,000)	Louisiana (51,000)
Ohio (89,000)	Massachusetts (50,000)
Pennsylvania (89,000)	

Why Do Americans Lose Their Health Insurance?

Americans lose their health insurance each month for a variety of reasons. Many are laid off from their jobs or have a spouse or parent who is laid off. They either cannot afford to continue paying their full health insurance premiums on their own, or are no longer eligible to do so.

Ms. H. is a laid off computer technician. To continue paying for health insurance for herself and two children would have cost her \$500 a month which, without a job, she could not afford.

Other Americans lose their health insurance when they change jobs. This can happen because many jobs require a waiting period before new employees are eligible for health benefits.

Mrs. S.'s husband recently lost his job at AT&T. They cannot afford the \$464 a month it would cost to maintain their health insurance through AT&T. Mrs. S. is a nurse and can only get insurance through the hospital for which she works beginning January 1, 1994. Mrs. S. has had meningitis twice and is afraid that, if it recurs during the period when they are without insurance, her family will be destroyed financially.

Often new coverage excludes preexisting health conditions, leaving individuals unprotected for those health problems for which they are most likely to need health insurance.

Larry P. injured his knee at home and required surgery to remove bone fragments and almost

all of the cartilage in his knee. When he left his job that required heavy lifting and took a new job at a video store, his new health insurance did not cover his knee.

Many Americans who are self-employed or work in small businesses lose their insurance when they can no longer afford the high premiums insurance companies charge individuals and small groups.

Patricia P., a self-employed office worker, was paying \$9,000 a year for a major medical policy with a \$1,000 deductible. This policy was her largest single expense, more than her mortgage. She had to drop her coverage.

Mrs. A. and her husband run a plumbing business. They had to drop their insurance when premiums increased from \$350 a month to \$550 a month.

Americans lose their health insurance when insurance companies take advantage of fine print to cancel coverage for those who need insurance the most—those who develop a serious health condition.

Dr. S. is a dentist. For 15 years he paid premiums for himself and his family. When he developed cancer, the insurance company first raised his premium from \$2,650 to \$10,000 a year, and then canceled the policy.

Jean and Tom M. own a small grocery store in rural Tennessee. For eight years they paid their health insurance premiums. When Tom developed cancer, the insurance company canceled his policy because "they were no longer profitable."

In other cases, insurance companies raise health insurance premiums for those with a serious health problem to the point where the insurance becomes unaffordable for individuals and for entire groups.

Mrs. B. needed angioplasty. Six months later her health insurance premiums went from \$215 a month to \$1,700. She had to drop her coverage.

Sometimes individuals lose their health insurance when insurance companies go bankrupt.

Nancy and Marshall M. paid \$500 a month for their insurance coverage, which had been recommended by Marshall's professional organization. In January of 1991, they had twins and one needed neonatal care because of a heart problem. Their insurance company was insolvent and did not pay their \$100,000 bill. They now have a collection agency breathing down their necks.

Among the Americans most likely to lose their health insurance are those who have graduated from college and are no longer eligible for coverage through their parents' policies.

Anna P. graduated from college in 1990. She came from Los Angeles to Washington D.C. to find a job. She was covered by her mother's policy until she turned 25. Now she has two jobs, neither of which offers health insurance. Her husband's job provides insurance that covers him, but it would cost them \$300 a month to cover her. As a young family, they can't afford that expense.

Number of Persons Losing Health Insurance Each Month By State, 1993

State	Average Number of Persons Losing Health Insurance Each Month
United States	2,255,000
Alabama	36,000
Alaska	6,000
Arizona	41,000
Arkansas	30,000
California	306,000
Colorado	41,000
Connecticut	23,000
Delaware	6,000
District of Columbia	6,000
Florida	113,000
Georgia	62,000
Hawaii	11,000
Idaho	13,000
Illinois	90,000
Indiana	44,000
Iowa	23,000
Kansas	20,000
Kentucky	32,000
Louisiana	51,000
Maine	11,000
Maryland	43,000
Massachusetts	50,000
Michigan	76,000
Minnesota	36,000
Mississippi	28,000
Missouri	43,000
Montana	12,000
Nebraska	14,000
Nevada	15,000
New Hampshire	9,000
New Jersey	46,000
New Mexico	21,000
New York	130,000
North Carolina	64,000
North Dakota	6,000
Ohio	89,000
Oklahoma	32,000
Oregon	27,000
Pennsylvania	89,000
Rhode Island	8,000
South Carolina	33,000
South Dakota	6,000
Tennessee	45,000
Texas	173,000
Utah	24,000
Vermont	5,000
Virginia	55,000
Washington	49,000
West Virginia	18,000
Wisconsin	36,000
Wyoming	6,000

SOURCE: Lewin-VHI estimates based on the 1990 Survey of Income and Program Participation, the 1987 National Medical Expenditure Survey and four years of pooled March Current Population Survey data.

Estimating the Number of Americans Losing Health Insurance

The estimates in this special report are based primarily on data from the 1990 Survey of Income and Program Participation (SIPP). The SIPP was conducted by the Bureau of the Census and contains the most extensive information to date about families' health insurance coverage on a month-by-month basis. The 65,369 persons interviewed as part of the SIPP represent the civilian, non-institutionalized population of the United States.

In order to update the estimates from the 1990 SIPP to 1993, Bureau of the Census estimates of the change in the population from 1990 to 1993 were used.

The state-by-state estimates are based on state-level estimates of the distribution of persons with health insurance for part of the year. These state-level estimates are based on a dataset that matched four years of the most recent March Current Population Survey (CPS) data to data from the 1987 National Medical Expenditure Survey (NMES). Due to the sampling frame and size of the pooled samples, the CPS data allow for state-level estimates.

The SIPP data allow examination of the number of persons losing health insurance of any kind, including private, Medicaid and other public insurance. Approximately 79 percent of all persons who lose their insurance were covered previously by private insurance.

Who Loses Health Insurance?

This special report focuses on the more than two million Americans who lose their health insurance each month. These Americans are likely to be without insurance for less than a year and have some distinctive demographic characteristics.

Based on data collected 1983 to 1986, half (48%) of those who lost insurance lacked health insurance for five months or less; 16 percent lacked insurance for six to nine months; and eight percent lacked health insurance for 10 to 13 months.¹

Based on 1987 data, 29 percent of those who lacked health insurance for part of the year lacked insurance for four months or less. Another 39 percent of those who lacked health insurance for part of the year lacked insurance for five to eight months. For those having private insurance for part of the year in 1987, one-third (34%) lacked insurance for four months or less. Another

38 percent of those who lost their private health insurance for part of the year lacked insurance for five to eight months.²

Based on the 1990 SIPP data, Americans who lose their health insurance have some distinctive demographic characteristics. Over one-third (36%) were full-time workers in the month before losing their insurance; almost one-third (30%) had family incomes of \$30,000 or more; and over one-fourth (27%) had at least some college education. Almost one-third (29%) of those who lost their insurance were under age 18. Sixteen percent of those who lost their insurance worked in professional and related services and 14 percent worked in manufacturing in the month prior to losing their insurance. These demographic groups are more highly represented among those who lost their insurance at some point during the year than among those who lacked insurance for the entire year.³

Other research has focussed on the demographic characteristics of those who lose their health insurance and are likely to experience relatively short periods without health insurance. This research shows that those who lose their health insurance for relatively short periods of time have the following characteristics immediately before losing their health insurance: annual family income above \$29,500; a high school diploma or higher educational level; and

employment in a number of industrial sectors (manufacturing, trade, utilities, finance/insurance/real estate, business services and professional services). Other characteristics of those who lose their health insurance for relatively short periods are: working full-time in the month prior to losing insurance and in the month of losing insurance; being between the ages of 18 and 24; living in the Northeast; and being married.⁴

Conclusion

More than two million Americans lose their health insurance each month. These Americans are likely to lack insurance for significantly less than a year. But, as many Americans have experienced, a period without health insurance, no matter how brief, can lead to financial catastrophe.

Americans who lose their health insurance suffer long-term consequences. When they gain new insurance coverage, that coverage is likely to exclude coverage for preexisting health conditions, the very conditions for which they are most likely to need insurance.

Endnotes

1. Katherine Swartz, John Marcotte and Timothy McBride, "Spells Without Health Insurance: The Distribution of Durations When Left-Censored Spells Are Included," *Inquiry* vol. 30, (Spring 1993), pp. 77-83.
2. Kathleen Short, *Health Insurance Coverage: 1987-1990*, U.S. Department of Commerce, Bureau of the Census, Current Population Reports, Household Economic Studies, Series P-70, n. 29, (Washington, D.C.: Government Printing Office, 1992).
3. Lewin-VHI analysis of the 1990 Survey of Income and Program Participation.
4. Katherine Swartz, John Marcotte and Timothy McBride, "Personal Characteristics and Spells Without Health Insurance," *Inquiry* vol. 30, (Spring 1993), pp. 64-68.

PEOPLE WHO WILL LOSE THEIR INSURANCE

Over two million Americans lose their health insurance each month.¹ Most of these people will lack insurance for less than five months, yet a significant portion will lack insurance for six months or more.² During this time, families are at grave financial risk if a member becomes sick or injured.

Jerry and Donna Weldon live in Fenton, Missouri with their two young children. Jerry is a plumber and the family is covered through Jerry's union. Every three months, Jerry must work a minimum number of hours in order to qualify for health insurance coverage. Lately, work has been slow and the number of hours required by the union for health insurance will be increasing. The Weldons' eight-year-old son has leukemia and he had a bone marrow transplant this fall. After this procedure, he will need ongoing medical care and prescription drugs. The Weldons are worried that they will lose their insurance in the future because of Jerry's lack of work and the increasing number of required hours for insurance.

CLINTON:

The Weldons would always have the same comprehensive insurance, regardless of how much work Jerry gets.

As of 1998, the Clinton bill would guarantee that no American would lose their health insurance, regardless of any changes in health, employment or economic status.

Workers and their families would receive insurance coverage through their employment. Self-employed or unemployed people and their families would purchase coverage directly. Their insurance premiums would be fully tax deductible, instead of only 25 percent deductible as they are now. Discounts would help businesses and families afford their premiums.

Families would choose from a variety of health plans offered by regional health alliances where they live. Employees of firms with more than

5,000 employees could choose from at least three plans offered by their firm.

COOPER:

The Weldons would still have to worry about losing health insurance.

Under the Cooper bill, all individuals, families and small businesses that choose to purchase health insurance would do so through their local cooperative. Employers would choose to contribute or not contribute to their employees' health insurance premiums, as they do now.

Employees and their families could still lose their health insurance if they lost their job; if they changed jobs; if their employer could no longer afford the premiums; if they retired before age 65; and for a variety of other reasons.

Low-income families and individuals who choose to purchase insurance would be eligible for some financial assistance.

Families and individuals who purchase insurance on their own could deduct from their taxes the premium for the lowest-priced plan.

CHAFEE:

The Weldons would have to worry about losing health insurance at least until the year 2005, and possibly longer.

Under the Chafee bill, all individuals, families and small businesses could choose to purchase insurance through a number of local purchasing groups or on their own. Employers would choose to continue to contribute or not contribute to their employees' health insurance premiums, as they do now.

In the year 2005, this bill would require all individuals and families to purchase insurance. This individual mandate would go into effect *only if* federal Medicare and Medicaid savings at that time are sufficient to finance premium assistance for individuals and families with incomes up to 240 percent of poverty.

Families and individuals who purchase insurance on their own could deduct the premium from their taxes, up to the average cost of the lowest-priced one-half of plans.

At least until the year 2005, and possibly longer, employees and their families could still lose their health insurance if they lost their job; if they changed jobs; if their employer could no longer afford the premiums; if they retired before age 65; and for a variety of other reasons.

1. Families USA Foundation, *Losing Health Insurance* (Washington, D.C.: Families USA Foundation, 1993).

2. Katherine Swartz, John Marcotte and Timothy McBride, "Spells Without Health Insurance: The Distribution of Durations When Left-Censored Spells are Included," *Inquiry* vol. 30, (Spring 1993), pp. 77-83.

INADEQUATE INSURANCE

Millions of Americans have inadequate insurance that can leave them with thousands of dollars in medical bills. Such inadequate coverage is most common for families who buy non-group coverage and can only afford or qualify for very limited coverage with high deductibles, high copayments or limitations in benefits. Families USA estimates that 18 million Americans who have insurance are currently spending ten percent or more of their pretax income on out-of-pocket health expenses, excluding expenses for nursing home care, health insurance premiums, Medicare payroll taxes, federal, state and local taxes, and wages lost because of their employers' costs for health insurance.¹ Economists generally consider individuals to be underinsured if they are at risk of spending ten percent or more of their income on out-of-pocket health costs.²

Susan and David Mast live in Wheaton, Maryland with their three young children. David Mast is a self-employed contractor. In 1992, his income was about \$20,000. He paid \$4,000 to purchase health insurance on his own for his family, but couldn't afford the extra \$4,000 a year maternity coverage would have cost. Even then, the coverage wouldn't have been effective for one year. Their son, Joshua, was born in February 1992. Susan Mast worked two jobs as a proofreader and typesetter and took in babysitting and accounting work to pay off the \$3,300 bill from that birth.

CLINTON:

The Mast family would have a choice of health insurance plans that provide comprehensive benefits, and would save about \$2,000 a year in premium costs.

The Clinton bill specifies a comprehensive benefit package that would cover a full range of services.

The guaranteed national benefits have no lifetime limitations on coverage and would include: hospital services; emergency services; services of physicians and other health professionals; mental health and substance abuse services; family planning services; pregnancy-related services; hospice care; home health care; extended-care services; ambulance services; outpatient laboratory and diagnostic services;

COOPER:

Would not guarantee the Mast family comprehensive health benefits.

The Cooper bill would require all health plans to provide a uniform set of effective benefits, but the bill fails to specify what benefits would be covered within the broad categories of medically appropriate treatments, the full range of effective clinical preventive services and a full range of diagnostic services. The bill does not specify limits on the amount families would have to pay in deductibles and copayments. The bill leaves these decisions to a Health Care Standards Commission and then to the Congress.

CHAFEE:

Would not guarantee the Mast family comprehensive health benefits.

The Chafee bill would require all health plans to provide a standard benefits package. The bill includes the following guidelines: medical and surgical services; prescription drugs; preventive services; medical equipment; rehabilitation and home health care after an acute care episode; severe mental illness services and substance abuse services; hospice care and emergency transportation services.

The guidelines do not specify annual limits on the amount families would have to pay for deductibles and copayments.

outpatient prescription drugs and biologicals; outpatient rehabilitation services; durable medical equipment, prosthetic and orthotic devices; vision and hearing care; dental services; and health education classes.

A variety of preventive services would be available at no cost. Prescription drug, dental, vision and mental illness services would be more generous than many plans today.

No individual would have to spend more than \$1,500 annually for covered services and no family would have to spend more than \$3,000 annually.

Based on national average premiums, the Mast family would pay approximately \$2,000 for health insurance, and that amount would be fully tax deductible.

The Health Care Standards Commission and the Congress could review annually the uniform set of effective benefits. Thus, benefits could be modified or eliminated every year.

Because their family income is under 200 percent of poverty, the Mast family would be eligible for some assistance to cover the cost of their premium. Given their income, the Masts would have to pay about 19 percent of the premium for the lowest-priced plan, and that amount would be tax deductible.

Since the Cooper bill does not specify a benefit package, it is impossible to determine the amount the Mast family would have to pay for premiums, deductibles, copayments and uncovered services.

Under this bill, a Benefits Commission would recommend a standard benefits package for approval by the Congress. The Commission could eliminate any of the categories of proposed covered items and services. This benefits package could be reviewed annually by the Benefits Commission and the Congress. Thus, benefits could be modified or eliminated every year.

Alternatively, health plans could offer a catastrophic benefit package that would cover the same services, but require very high deductibles and copayments. These plans would leave most families with high uncovered health costs.

Furthermore, families and businesses would have to pay taxes on any benefits that are not included in the standard benefits package and on insurance premiums that are higher than the average of the lowest-priced one-half of plans.

Because their family income is under 240 percent of poverty, the Mast family might be eligible for some assistance to cover the average cost of the lowest-priced one-half of plans offered in the area. Such assistance would be available only if the federal government realizes sufficient savings in the Medicaid and Medicare programs to fund the premium assistance.

If assistance becomes available, beginning in 1999, the Masts would have to pay about 13 percent of the premium, and that amount would be tax deductible, up to the average cost of the lowest-priced one-half of plans.

Since the Chafee bill includes only guidelines for the standard benefits package, it is impossible to determine the amount the Mast family would have to pay for premiums, deductibles, copayments and uncovered services.

1. Families USA Foundation, *Half of Us: Families Priced Out of Health Protection* (Washington, D.C.: Families USA Foundation, 1993).

2. Pamela J. Farley, "Who Are the Underinsured?" *Milbank Memorial Fund Quarterly/Health and Society* vol. 63, no. 63, (1985), pp. 477-501.

EARLY RETIREES LOSING HEALTH BENEFITS

One-third (32%) of all retirees who have health insurance coverage through their former employers are under age 65.¹ In light of skyrocketing health care costs and new accounting rules requiring employers to report this liability, companies are cutting health benefits for current and future retirees. A recent major survey of larger corporations found that 12 percent of companies responding have eliminated or plan to eliminate all retiree health benefits. Another 56 percent have reduced or plan to reduce health benefits covered.²

Kazimer "Casey" Patelski and his wife Bonnie live in Costa Mesa, California. Casey was a design engineer for McDonnell Douglas for 28 years. He helped design various aircraft, missiles, satellites and the Skylab Space Station. Casey, who suffered from polio as a young man, turned down numerous job offers from other companies over the years because of the generous retirement benefits, including health insurance, promised by McDonnell Douglas. When Casey retired at age 63, he was assured that he and Bonnie would have health insurance coverage for the rest of their lives. A year later, McDonnell Douglas announced that it was eliminating health insurance benefits for all retirees. Current retirees, like the Patelskis, were allowed to purchase health insurance coverage with their pension funds.

CLINTON:

The federal government would pay 80 percent of the Patelskis' health insurance premiums until Mr. Patelski was eligible for Medicare.

The Clinton bill would provide early retirees and their families with guaranteed health coverage. Under this bill, the federal government would pay 80 percent of premiums for retirees between the ages of 55 and 65. For retirees whose previous employers currently pay retiree health costs, their employers would now pay the retirees' share of premiums (20 percent).

COOPER:

The Patelskis would still have to pay 100 percent of their health insurance premiums.

The Cooper bill would provide no federal assistance for early retirees who are not yet eligible for Medicare, or their families.

If the Patelskis choose to buy insurance, under this bill they would buy that insurance through their local purchasing cooperative. Their premiums would probably be less than if they had to buy insurance on their own, but they could pay higher premiums than others in the purchasing cooperative because of their age.

CHAFEE:

The Patelskis would still have to pay 100 percent of their health insurance premiums.

The Chafee bill would provide no federal assistance for early retirees who are not yet eligible for Medicare, or their families.

If the Patelskis buy insurance under this bill, they could choose to purchase it through a number of local purchasing groups or on their own. Their premiums might be somewhat less than what they would pay currently, but they would pay higher premiums than others in their area because of their age.

1. Steven DiCarlo, Jon Gabel, Gregory de Lissoy and Judith Kasper, *Research Bulletin: Facing Up to Postretirement Health Benefits* (Washington, D.C.: Health Insurance Association of America, 1989).

2. Hewitt Associates, *FASB Retiree Health Accounting* (Lincolnshire, IL: Hewitt Associates, October 1993).

SMALL BUSINESS OWNERS AND THEIR FAMILIES

Small business owners, employees and their families encounter great difficulties obtaining affordable health insurance. Small groups generally must pay ten to 40 percent more for health insurance than large groups. Those who would purchase health insurance as individuals or as part of a small business group face another formidable barrier to health coverage—medical underwriting practices. Medical underwriting is the process by which an insurer evaluates the health history and the potential for poor health status, and high claims, for an individual or group. Based on current underwriting practices, approximately 15 percent of all small businesses are ineligible for insurance or eligible only for restricted coverage.¹

Ann and Hubert Maddux live in Corpus Christi, Texas with their four-year-old daughter and infant son. Hubert runs a tackle shop and makes approximately \$25,000 a year. As a small business owner, the best insurance Hubert could get for himself and his family was through his alma mater in 1986. At that time his premiums were \$1,000 a year. After their daughter was born with Downs Syndrome and serious heart defects, the Maddux family's premiums increased to \$17,000 annually. For the last two years, the Madduxes have cut back on their insurance coverage because of the high costs. As of January 1994, the Madduxes pay \$8,520 a year for their insurance. But the policy requires a \$5,000 deductible per person, and payment of half of the first \$10,000 in covered expenses per person. Both children need prescription drugs which the family's insurance does not cover. Medicine for the children costs the family between \$100 and \$200 per month.

CLINTON:

The Maddux family would save about \$5,700 on health insurance premiums and would have a choice of plans that provide comprehensive benefits. They would have to spend no more than \$3,000 out of pocket annually for their family's health care.

Under the Clinton bill, most Americans would obtain their insurance through consumer-controlled regional health alliances. This pooling of individuals and businesses would result

COOPER:

The amount the Maddux family would pay for premiums and the coverage they would have, including deductibles and copayments, are unknown.

Under the Cooper bill, the Maddux family and other small businesses and individuals who choose to purchase health insurance would purchase it through their local purchasing cooperative. Since not all small

CHAFEE:

The amount the Maddux family would pay for premiums and the coverage they would have, including deductibles and copayments, are unknown.

Under the Chafee bill, the Maddux family and all others who purchase health insurance could purchase it through a number of local purchasing groups or on their own. Each

in lower premiums for those who previously purchased insurance alone as small businesses or individuals. The Maddux family would pay the same premium as all others under age 65 purchasing insurance through the alliance.

Small businesses and individuals would no longer see their premiums skyrocket from year to year. This bill would limit the amount by which insurance companies can raise premiums each year so that, by the end of the decade, premiums would go up no faster than inflation.

Insurers would no longer be able to set the premiums for small businesses on the basis of that group alone. Instead, premiums would be based on health costs for the entire region. Insurers would no longer be able to reject businesses or individuals for any reason.

Small businesses would be eligible for significant federal discounts on premiums. No business would have to spend more than 7.9 percent of its payroll for health insurance costs. Businesses with 75 or fewer employees would pay less if their average wages are \$24,000 or less. The lowest wage small businesses would pay only 3.5 percent of payroll.

Many small business owners would pay less to cover themselves, their families and their employees than they now pay just to cover themselves and their families. Based on national average premiums, the Maddux family, for example, would pay no more than about \$2,800 for health insurance premiums. This amount would be fully tax deductible. The amount the Madduxes currently pay for health insurance would cover the cost for the Maddux family and two additional families under the Clinton bill.

businesses and individuals would choose to purchase insurance, the purchasing cooperatives would not pool as much risk or have as much negotiating power as if all small businesses and individuals had to purchase insurance through the cooperative.

The Maddux family's premiums would differ from others who purchase insurance through the cooperative based on their age. Any plan that denied coverage to any person, family or group because of one person's health condition would not be tax deductible.

This bill does not specify the standard benefits, or the deductibles and copayments.

Small businesses and families could deduct the cost of their health insurance premiums, up to the cost of the lowest-priced plan, and only for the benefits included in the unspecified uniform set of benefits. Small businesses would not receive any discounts on premiums for low-wage workers, nor would there be a cap on the percentage of payroll spent for premiums.

There are no limits on the amount premiums could increase each year.

Since this bill provides no subsidies for small businesses, small business owners and their families would be eligible only for individual subsidies. Families and individuals with incomes under 100 percent of poverty would be fully subsidized for the cost of the lowest-priced plan and would pay ten percent of the difference between the cost of the lowest-priced plan and higher-priced plans. Families and individuals with incomes between 100 percent and 200 percent of poverty would pay the percentage of their income that is above the poverty line for the lowest-priced plan and that same percentage of the difference between the cost of the lowest-priced plan and higher-priced plans.

Since the Maddux family's income is 74 percent above the poverty line, they would pay 74 percent of the cost of the premium for the lowest-priced plan. This amount would be tax deductible.

Since the Cooper bill does not specify a standard benefits package, it is impossible to determine the amount the Maddux family would pay for premiums, deductibles, copayments and uncovered services.

purchasing group would therefore not pool as much risk or have the same negotiating power as if everyone in a region purchased insurance through one group.

The Maddux family's premiums would differ from others in their area based on how they purchase their insurance and on their age. Plans could not deny coverage to any person, family or group because of one person's health condition.

This bill provides guidelines for a Benefits Commission to use in recommending a standard benefits package to Congress, but the bill does not specify the amount families and individuals would have to pay in deductibles and copayments.

Small business owners and their families could deduct the cost of their health insurance premiums, up to the average cost of the lowest-priced one-half of health plans offered in the area. Small businesses would not receive any discounts on premiums for low-wage workers, nor would there be a cap on the percentage of payroll spent for premiums.

There are no limits on the amount premiums could increase each year.

Since this bill provides no subsidies for small businesses, small business owners and their families would be eligible only for individual subsidies. If federal Medicare and Medicaid savings are sufficient to fund premium assistance, this bill would phase in assistance for families and individuals with incomes up to 240 percent of poverty, from 1997 to 2005.

If such assistance becomes available, as of 2002 the Maddux family would pay about 53 percent of the cost of the average of the lowest-priced one-half of plans offered in the area. This amount would be tax deductible.

Since this bill includes only guidelines for the standard benefits package, it is impossible to determine the amount the Maddux family would pay for the premiums, deductibles, copayments and uncovered services.

EMPLOYEES VULNERABLE TO ARBITRARY LIMITS ON BENEFITS

Approximately 40 percent of all employees and their families are covered by employer health plans that are self-insured.¹ Self-insured companies do not purchase health insurance from a private insurance company. Instead, they pay the cost of their employees' medical care directly. The U.S. Supreme Court recently ruled that self-insured employers may limit or eliminate health insurance benefits at any time, even after an employee or a family member contracts a serious illness.

John and Joan Cleveland of St. Louis, Missouri had health insurance through Joan's employer, a company that is self-insured. John was diagnosed with leukemia in September 1990, and he needed a bone marrow transplant. Even though his insurance had a \$500,000 lifetime maximum, the policy capped coverage of organ and tissue transplants at \$75,000. John's transplant cost about \$250,000. John died of complications from his transplant in June 1993.

CLINTON:

John and Joan Cleveland would have had to pay no more than \$3,000 out of pocket for John's medical care in the year that he had his bone marrow transplant.

The Clinton bill would prohibit all employers and insurers from imposing caps or exclusions on coverage for specific medical conditions or any lifetime limit on benefits for covered services. The bill would require all businesses, whether they pay for their employees through a regional health alliance or through their own corporate alliance, to provide the comprehensive benefits specified by federal law. John Cleveland's bone marrow transplant would have been covered.

COOPER:

Joan Cleveland's employer could not impose arbitrary limits on the Clevelands' health benefits, but it is impossible to know if John's bone marrow transplant would have been covered. It is impossible to determine the amount the Clevelands would have had to pay out of pocket for John's medical care.

The Cooper bill would prohibit all employers who provide insurance, either through a purchasing cooperative or on their own, from limiting any benefits in the uniform set of benefits.

The bill, however, does not specify the uniform set of effective benefits within the broad categories of medically appropriate treatments, clinical preventive services and diagnostic services. The bill also does not specify the amount families would have to pay in deductibles and copayments. The uniform set of benefits could include limits on benefits for specific treatments or diseases. The bill leaves these

decisions to a Health Care Standards Commission and then to the Congress.

The Health Care Standards Commission and the Congress could review annually the uniform set of benefits. Thus, benefits could be modified or eliminated every year.

CHAFEE:

Joan Cleveland's employer could not impose arbitrary limits on the Clevelands' health benefits, but it is impossible to know if John's bone marrow transplant would have been covered. It is impossible to determine the amount the Clevelands would have had to pay out of pocket for John's medical care.

The Chafee bill would prohibit all employers who provide insurance, either through a purchasing group or on their own, from limiting any benefits in the standard benefits package.

The bill, however, does not specify the standard benefits package. The bill provides guidelines for covered services that a Benefits Commission would use in recommending a standard benefits package to Congress. The bill also does not specify the amount families and individuals would have to pay in deductibles and copayments. The standard benefits package could include dollar limits on benefits for specific treatments or diseases.

The Benefits Commission and the Congress could review annually the standard benefits package. Thus, dollar limits on benefits could be modified every year.

1. Cynthia B. Sullivan, Marianne Miller, Roger Feldman and Bryan Dowd, "Employer-Sponsored Health Insurance in 1991," *Health Affairs* vol. 11, no. 4, (Winter 1992), pp. 172-185.

CARE UNAVAILABLE FOR MEDICAID BENEFICIARIES

Low-income Americans face numerous barriers to medical care, even when they are covered by Medicaid, the government's health insurance program for low-income persons. Last year, almost one out of five adults receiving Medicaid were turned away by a hospital or a doctor. Another 20 percent had to go to an emergency room for care because they did not have a regular doctor.¹

In late 1990, Sherri Wilburn of Blount County, Tennessee learned she was pregnant. Although she qualified for Medicaid coverage, neither Sherri nor a social worker at the local health department could find a doctor willing to provide Sherri with prenatal care. Sherri was finally able to schedule her first doctor visit for in her seventh month of pregnancy. Three days before her scheduled appointment to begin prenatal care, Sherri went into labor. Her daughter, Cassandra, suffered brain damage and was hospitalized for months. Cassandra will need special education and ongoing physical therapy. According to one of Cassandra's doctors, Sherri's pregnancy was "complicated by a lack of prenatal care."

CLINTON:

Sherri Wilburn would have her choice of any insurance plan offered in her region with an average premium or lower.

Under the Clinton bill, all Medicaid beneficiaries would have access to the same plans offered by the regional health alliances as everyone else.

For individuals like Sherri Wilburn who are eligible for Aid to Families with Dependent Children (AFDC) or individuals who receive Supplemental Security Income (SSI), the Medicaid program would make payments to the health alliances and allow beneficiaries to choose among all health plans with premiums equal to or below the average.

Those who receive cash assistance would be responsible for very small copayments. They would continue to receive all mandatory Medicaid benefits and any optional benefits that the state chooses to provide that are not included in the comprehensive benefits package.

Sherri's daughter would be eligible for services through a new federal program for low-income children with special needs.

Persons currently receiving Medicaid, but not receiving cash assistance, would obtain their health insurance through their regional health alliance in the same manner as all other persons. Persons with incomes below 150 percent of poverty would be eligible for some assistance with their premium costs.

COOPER:

Sherri Wilburn would be fully subsidized for only the lowest-priced plan offered by her local purchasing cooperative.

Under the Cooper bill, Medicaid would be replaced. The funds would be used to pay the premium for the lowest-priced plan offered by the local purchasing cooperative for individuals and families with incomes under 100 percent of poverty.

All individuals and families with incomes between 100 and 200 percent of poverty would be eligible for some assistance with the cost of the premium for the lowest-priced plan, based on a sliding scale. All individuals and families with incomes under 200 percent of poverty would be responsible for only a portion of the difference in premiums between the lowest-priced plan and higher-priced plans and for reduced deductibles and copayments.

For those with incomes under 100 percent of poverty, the Cooper bill would cover prescription drugs, hearing aids and eye-glasses and other benefits currently covered by Medicaid and not included in the standard benefits package.

CHAFEE:

Sherri Wilburn would continue to be covered through the Medicaid program. The state of Tennessee could choose how to provide her care.

Under the Chafee bill, the Medicaid program would continue. States could choose how to provide care. They could provide vouchers for beneficiaries to purchase care through a private purchasing group; enroll beneficiaries directly in a managed care plan; or develop an alternative way to provide health care. Whether or not Medicaid beneficiaries would have better access to services like prenatal care is uncertain.

The Chafee bill limits the amount that Medicaid spending could increase, without limiting how much private insurance could increase. Private insurance payments to providers would therefore be likely to increase faster than Medicaid payments and providers would prefer patients with private insurance to patients with Medicaid. The access problems of Medicaid beneficiaries would worsen.

1. Kaiser Family Foundation, "News Release: New Survey Shows Significant Gaps in Medicaid Safety Net" (Menlo Park, CA: Kaiser Family Foundation, March 17, 1993).

HIGH PRESCRIPTION DRUG COSTS

An estimated 72 million Americans currently lack health insurance for prescription drugs.¹ Medicare does not cover outpatient prescription drug costs. Elderly persons take more prescriptions, on average, than younger people and have higher drug costs, but less than half (49%) of all elderly Americans have prescription drug coverage.² As a result, elderly persons pay almost two-thirds (64%) of their prescription drug costs out of pocket.³

Iona O'Neill is an 83-year-old resident of Spring Hill, Florida. Iona's income from Social Security is less than \$700 per month. She has no insurance covering prescription drug costs. Iona suffered bladder cancer and now spends \$300 per month on medicine. Her income is too high, however, to qualify for any public assistance with prescription drug costs.

CLINTON:

Iona O'Neill would not have to pay more than \$1,132 a year for prescription drugs.

As of January 1, 1996 under the Clinton bill, Medicare beneficiaries would be eligible for a new outpatient prescription drug benefit.

After an annual deductible of \$250 per person, Medicare beneficiaries would pay only 20 percent of prescription drug costs up to an annual maximum of \$1,000 (including the deductible). After reaching that maximum, Medicare would cover all drug costs. The benefit would be part of Medicare Part B. Medicare beneficiaries pay Part B premiums that cover 25 percent of Part B costs. The additional Part B premium for the prescription drug benefit would be approximately \$11 per month. After 1996, the deductible and out-of-pocket maximum would increase only for inflation.

Those Medicare beneficiaries who purchase Medigap insurance will also benefit from this new coverage. Three of the ten Medigap policies on the market today have prescription drug coverage. The most generous

COOPER:

Iona O'Neill would still have to spend \$3,600 or more a year for prescription drugs.

The Cooper bill would not expand Medicare coverage to include prescription drugs.

For those under age 65, the Cooper bill does not require coverage of all prescription drug costs. A Health Care Standards Commission would define, and the Congress would approve, a uniform set of effective benefits that provide medically appropriate treatment. As part of the uniform set of effective benefits, the Commission also would specify the level of deductibles and copayments.

The uniform set of benefits could be reviewed annually by the Health Care Standards Commission and the Congress. Thus, benefits could be modified or eliminated every year.

The Cooper bill would cover prescription drugs for persons with incomes under 100 percent of poverty.

CHAFEE:

Iona O'Neill would still have to spend \$3,600 or more a year for prescription drugs.

The Chafee bill would not expand Medicare coverage to include prescription drugs.

For those under age 65, the guidelines for the standard benefits package include prescription drug coverage. However, the Benefits Commission can eliminate categories within these guidelines and the guidelines do not specify the deductibles and coinsurance individuals and families would have to pay for this benefit.

Under this bill, a Benefits Commission would recommend a standard benefits package, with deductibles and copayments, to the Congress. This benefit package could be reviewed annually by the Benefits Commission and the Congress. Thus, benefits could be modified or eliminated every year.

Under the Chafee bill, the Medicaid program would continue. All states currently provide prescription drug coverage for Medicaid beneficiaries.

prescription coverage available through Medigap has a \$250 deductible, 50 percent coinsurance and a \$3,000 maximum annual benefit. Medicare beneficiaries who purchase Medigap insurance with some prescription drug coverage will be able to save money by purchasing policies without this coverage *and* see their benefits improve.

All Americans under age 65 also would have coverage for prescription drug costs as of 1998 under the Clinton bill. Under the lower cost-sharing plan, individuals and families would pay only \$5.00 per prescription. Under the higher cost-sharing plan, after meeting a \$250 deductible per person, individuals and families would pay only 20 percent of prescription drug costs. If an individual's health costs exceeded \$1,500 or a family's costs exceeded \$3,000 in a year, they would no longer have to make any additional payments for prescription drugs.

1. John Rother, "Statement of the American Association of Retired Persons on the Health Care Crisis in America: A Growing Threat to Economic Security," Testimony before the Joint Economic Committee, U.S. Congress (Washington, D.C.: AARP, September 15, 1993).
2. American Association of Retired Persons Public Policy Institute, "Older Americans and Prescription Drugs: Utilization, Expenditures and Coverage," *Issue Brief Number Nine* (Washington, D.C.: AARP, September 1991).
3. Families USA Foundation, *Prescription Costs: America's Other Drug Crisis* (Washington, D.C.: Families USA Foundation, 1992).

JOB LOCK

American families with a member who has a chronic health condition can easily find themselves in the position of being unable to change jobs because the family is dependent on the health insurance obtained through one family member's job. One in five (19%) workers report that they or a family member are locked in their jobs because new work offers limited or no health insurance.¹

Melanie and Randy Wood live in Houston, Texas with their three children. After her third child was born, Melanie intended to leave her job to become a full-time mother. At the time, the family had health insurance coverage through Melanie's job. Jordan, now ten, was born with Sturge-Weber syndrome, a congenital neurological disorder. Jordan also has hydrocephalus and needs a shunt to drain excess fluid from his brain. Melanie started calling insurance companies immediately after Jordan's birth and found that Jordan was uninsurable. Since Randy is self-employed, Melanie was forced to return to work in order to keep health insurance for her family.

CLINTON:

Melanie Wood could become a full-time mother and the Wood family would have a choice of health insurance plans for the same premium as everyone else, approximately \$2,000 a year.

The Clinton bill would eliminate job lock because it guarantees all Americans affordable, comprehensive health coverage.

As of 1998, all employers would contribute 80 percent of average premium costs for health insurance for workers and their families, or more if they choose. As a result, workers would no longer have to choose

COOPER:

If Melanie Wood became a full-time mother, the family could purchase insurance and would be eligible for assistance with premium costs, but there is no way of knowing what benefits their premiums would cover and what out-of-pocket expenses they would have. This bill would not eliminate job lock for workers who wish to change from a job with health benefits to a job that does not have health benefits.

The Cooper bill would not eliminate job lock. Since employer contributions to health insurance would remain voluntary, most employers who do not contribute to health insurance now would not in the future. Thus, workers would still have to choose between jobs that offer health insurance benefits and those that do not.

Individuals and small businesses could purchase insurance through their

CHAFEE:

If Melanie Wood became a full-time mother, the family could purchase insurance and might be eligible for assistance with premium costs, but there is no way of knowing what benefits their premium would cover and what out-of-pocket expenses they would have. This bill would not eliminate job lock for workers who wish to change from a job with health benefits to a job that does not have health benefits.

The Chafee bill would not eliminate job lock. Since employer contributions to health insurance would remain voluntary, most employers who do not contribute to health insurance now would not in the future. Thus, workers would still have to choose between jobs that offer health insurance benefits and those that do not.

Individuals and small businesses could purchase insurance on their own

between jobs that offer health benefits and those that do not.

This insurance would be affordable for small businesses and individuals because low-wage businesses and individuals would be eligible for discounts on premiums; because no business or self-employed individual would have to spend more than 7.9 percent of their payroll on premiums; and because premiums could increase no faster than inflation by the end of the decade.

Immediately upon enactment, the Clinton bill would prohibit insurers from excluding pre-existing conditions for individuals and their families who were insured within the previous 90-day period. For individuals and their families who were not previously insured, insurers could limit coverage for pre-existing conditions for no more than six months. This bill also would require insurers to accept immediately all newly-hired, full-time employees and their families added to groups currently insured. By 1998, this bill would prohibit exclusions for pre-existing conditions under any circumstances.

If Melanie Wood stayed home with her children, the Wood family would purchase their insurance through their regional health alliance and have the same choices as everyone else in the region. They would be eligible for significant discounts on their premiums based on their income. Based on national average premiums, the Wood family would pay approximately \$2,000 a year for comprehensive health insurance. Since Randy Wood is self-employed, that amount would be fully tax deductible.

local purchasing cooperative. The premium cost would be tax deductible, but only up to the cost of the lowest-priced plan. Insurance premiums would vary by age. Any plan that denied coverage to any person, family or group because of one person's health condition would not be tax deductible. For individuals and families who lacked insurance coverage for three months, insurers could limit coverage for six months for any pre-existing condition that appeared in the last three months.

The Cooper bill would not limit the amount insurance premiums could increase each year. It would not provide any discounts to small businesses or self-employed persons, or limit the percentage of payroll they could spend on premiums.

Under this bill, individuals and families with incomes under 100 percent of poverty would be fully subsidized for the cost of the lowest-priced plan and would pay ten percent of the difference between the cost of the lowest-priced and higher-priced plans. Individuals and families with incomes between 100 and 200 percent of poverty would pay a percentage of the premium equal to the percentage their income is above the poverty line for the lowest-priced plan and that same percentage of the difference between the cost of the lowest-priced plan and higher-priced plans.

Since Randy Wood is self-employed, the Woods could purchase insurance through their local purchasing cooperative. Since the Woods' income from Randy's business is 19 percent above the poverty line, the Woods would pay about 19 percent of the premium of the lowest-priced plan. Since Randy Wood is self-employed, this cost would be tax deductible. Since the Cooper bill does not specify a standard benefits package, it is impossible to determine the amount the Woods would have to pay for premiums, deductibles, copayments and uncovered services.

or through a number of local purchasing groups. The premium cost would be tax deductible, but only up to the average cost of the lowest-priced one-half of plans offered in the area. Insurance premiums would vary by age. Plans could not deny coverage to any person, family or group because of one person's health condition. For individuals and families who lacked insurance coverage for three months, insurers could limit coverage for six months for any pre-existing conditions that appeared in the last three months.

The Chafee bill would not limit the amount insurance premiums could increase each year. It would not provide any discounts to small businesses or self-employed persons, or place any limit on the percentage of payroll they could spend on premiums.

Under this bill, individuals and families with incomes under 100 percent of poverty would be fully subsidized for the cost of the lowest-priced one-half of plans offered in the area, and individuals and families with incomes between 100 and 240 percent of poverty could be eligible for some assistance with the cost of premiums. Such assistance would be available only if the federal government realizes sufficient savings in the Medicare and Medicaid programs to fund the premium assistance.

The Woods could purchase health insurance coverage through a number of local purchasing groups or on their own. The premium cost would be tax deductible, but only up to the average cost of the lowest-priced one-half of plans offered in the area.

Since the Woods' income from Randy's business is 19 percent above the poverty line, as of 1999 the Woods would pay about 13 percent of their premium cost, up to the average of the lowest-priced one-half of the plans offered in the area, if premium assistance becomes available. Since Randy Wood is self-employed, this cost would be tax deductible.

Since the Chafee bill includes only guidelines for a standard benefits package, it is impossible to determine the amount the Wood family would have to pay for premiums, deductibles, copayments and uncovered services.

1. Henry J. Kaiser Family Foundation and Louis Harris and Associates. "News Release: One in Five American Families Victim of 'Job Lock.' High Cost and Lack of Insurance Top Reasons" (Menlo Park, CA: Kaiser Family Foundation, October 15, 1993).

LONG TERM CARE AT HOME

At any given time, there are an estimated three and one-half million Americans who have great difficulty taking care of themselves. These persons require assistance with three or more of the five most basic activities of daily living—eating, bathing, toileting, dressing and getting out of a bed or chair. The services that they need are largely non-medical in nature and, as a result, options for financial assistance or insurance coverage are very limited. Approximately half of these Americans currently do not receive any paid home care services.¹

Roz and Harold Barkowitz live in North Miami Beach, Florida. Harold is a 72-year-old retired shoemaker who had to give up his business six years ago to care for Roz, age 67, who has multiple sclerosis. They had to sell their house and move into an apartment because Roz could no longer climb the stairs. They get no outside assistance caring for Roz, only someone who comes to clean once a week. Harold's greatest fear is that something will happen to him and he will no longer be able to care for Roz. He currently spends 24 hours a day taking care of her.

CLINTON:

Mr. and Mrs. Barkowitz would be eligible for services to assist Mr. Barkowitz with caring for his wife. The new program would ensure such care is affordable.

The Clinton bill establishes a major new program to provide services to individuals with severe disabilities without regard to age. Beginning in 1996, the federal government would provide significant new funds for states to develop plans of care for, and provide services to, persons with severe disabilities.

These persons would be eligible for services that include personal assistance and a wide variety of other services that would help them continue to live in their homes and community. This new program would be fully phased in by the year 2003. Individuals would be responsible for modest copayments based on income.

COOPER:

The Barkowitzes would receive no assistance.

The Cooper bill does not provide families any new assistance with providing long term care at home.

Under this bill, states would become entirely responsible for long term care expenses currently financed jointly by the federal government and states through the Medicaid program. Thus, fewer services could be available than currently.

CHAFEE:

The Barkowitzes would receive no assistance.

The Chafee bill does not provide families any new assistance with providing long term care at home.

1. Data provided by Lewin-VHI, Inc. This estimate includes persons with physical disabilities only. Due to limitations in the data, it does not include persons with cognitive impairments.

EMPLOYERS WITH SKYROCKETING PREMIUMS

The amount American families and businesses are charged for health care has far outpaced increases in family income and business profits. Today, business spending for health care nearly equals the amount corporations make in after-tax profits. By contrast, in 1980, business health care spending amounted to 41 percent of corporations' after-tax profits.¹ If health care inflation had been held to the same rate of inflation as the rest of the economy from 1980 to 1992, health care costs for businesses today would be one-third less than they are. This difference averages about \$1,000 per worker.²

Roger Flaherty owns a small company, Floor Covering Resources, in Kensington, Maryland. He has two employees, and they are covered by a small group health insurance plan. Both employees have ongoing health problems. In 1987 Roger paid \$285 a month to cover these employees. In November 1993, his premiums increased to \$885 a month. The business pays the full cost of the insurance. Roger is committed to providing health insurance for his employees, but doesn't know if he can continue to afford it.

CLINTON:

Mr. Flaherty would see his health insurance premiums for his employees go up no faster than inflation by 1999.

The Clinton bill would limit the amount by which all insurance companies could raise premiums. By 1999, American families would no longer have to swallow health insurance premium increases that are larger than general inflation. American families would see larger wage increases and more disposable income and businesses would see less of their profits eaten up by health cost increases and have more money to invest and to create new jobs.

COOPER:

Mr. Flaherty and other employers would see their health insurance premiums continue to climb uncontrollably.

The Cooper bill does not limit the amount health insurance premiums could increase annually. Mr. Flaherty's expenses could continue to increase far faster than inflation. Employers and workers would not be protected from the devastating economic effects of rapidly rising health insurance premiums.

CHAFEE:

Mr. Flaherty and other employers would see their health insurance premiums continue to climb uncontrollably.

The Chafee bill does not limit the amount health insurance premiums could increase annually. Mr. Flaherty's expenses could continue to increase far faster than inflation. Employers and workers would not be protected from the devastating economic effects of rapidly rising health insurance premiums.

1. Cathy A. Cowan and Patricia A. McDonnell, "Business, Households and Governments — Health Spending 1991," *Health Care Financing Review* vol. 14, no. 3, (Spring 1993), pp. 227-248.

2. Service Employees International Union, *Out of Control, Into Decline: The Devastating 12-Year Impact of Healthcare Costs on Worker Wages, Corporate Profits and Government Budgets* (Washington, D.C.: SEIU, October 1992).

Mr. JACOBS. Thank you all. Mr. Ford.

Mr. FORD. Thank you, Mr. Chairman.

Mr. Delaney, are your concerns focused around independent contractors being able to define their status more so than falling under the Clinton health care plan?

I noticed that you had four bullet points. It is responsible for the HSA changing the rules defining employee status in a way that would make it increasingly difficult for a worker to qualify as an independent contractor.

Mr. DELANEY. It certainly is, Congressman, with respect to Subtitle C. That is the redefinition of "employee" that is granted exclusively to the Treasury Department. But broader than that, we are concerned about the imposing of the mandate on the independent contractor as an employer.

Mr. FORD. What about the current rules governing independent contractors as they relate to health coverage? What percent of the independent contractors receive health care coverage?

Mr. DELANEY. I cannot answer that. I don't know.

Mr. FORD. Under the Clinton plan, would it be less?

Mr. DELANEY. I don't think so, because it would be assumed that they would be broadly defined to be employees. And the consequence of that is on the employer mandate. They would be, if there was no change in definition, an employer, and they would have to provide insurance in accordance with their premium level, and would be entitled to subsidies and the whole series of HSA provisions.

Mr. FORD. I want to move to Dr. Coleman a minute. You talked about public assistance programs providing many of the Medicaid and other health care benefits for the poor of this country. How do you respond to those with the Federation of Independent Businesses, who testified that they have a real problem with mandates?

You sort of suggest that either we are going to provide health care through public assistance programs or we are going to provide it through emergency rooms. Those who are the working poor, without health coverage, walk into the emergency rooms of this country and they receive health care. They have access. In many cases small businesses and others who carry health insurance pay for that care through the next year's premium.

Mr. COLEMAN. Congressman, you are absolutely correct. You have actually answered my question. It is going to be paid for one way or the other. And the system we have now pays for it in the more expensive way. I myself can pay my insurance premium, but I heard comments today that 85 percent of the people are covered and are well-satisfied with their insurance.

I have insurance that has a \$1,000 deductible. It covers only myself and my wife. I have never used it in the 15 years I have had it, and it went up \$200 a quarter this year, \$800 for the year, at a time I have heard today that everything is coming down.

So expenses are not coming down. It is being paid for in the private sector. And I think that the President's plan will shift some of that to the private sector but it will do it more fairly. Moreover, the plan does have subsidies and the savings that are gained in Medicare and Medicaid, which can be rolled over to finance those subsidies and supplement the private sector.

If we do not have a private and public sector working together and employers and employees honestly sharing the burden, what might not be a crisis today but is a major crisis—

Mr. FORD. Thank you very much.

Mr. JACOBS. Mr. Kleczka.

Mr. KLECZKA. No questions.

Mr. JACOBS. I have several questions but we do not have time. We will include your entire statements, of course, in the record, and the committee thanks the panel for its contribution.

Will the next panel please come forward.

Mr. JACOBS. The next panel consists of Michael Becker, vice president of benefits, McDonnell Douglas Corp.; Van L. Richey, president and CEO of American Cast Iron Pipe Co.; Anthony C. Williams, director, retirement, safety and insurance department with the National Rural Electric Cooperative Association; and George Pantos, Washington Counsel for the Self Insurance Institute of America, Inc.

Mr. Becker, you are recognized with 3 minutes.

STATEMENT OF MICHAEL R. BECKER, VICE PRESIDENT OF BENEFITS, MCDONNELL DOUGLAS CORP., ON BEHALF OF CORPORATE HEALTH CARE COALITION

Mr. BECKER. Mr. Chairman and members of the committee, my name is Michael R. Becker. I am vice president of benefits for the McDonnell Douglas Corp. I am here today on behalf of the Corporate Health Care Coalition, a group of large self-insured, multi-State employers. The coalition has 20 member companies at present. In combination we provide health care benefits for over 3.2 million lives, that is 1.26 percent of the U.S. population in all 50 States, at a cost of more than \$7 billion per year.

We have extensive experience in designing and operating health benefits and have been a major force in ongoing efforts to restructure the health care delivery system.

Let me be clear, our coalition has not endorsed any of the health care bills that have been introduced. None of the health care proposals encompass our vision of reform. We believe an employer-based system with employers and employer groups operating as direct aggressive purchasers is the most effective way to produce efficient health care results.

It is critical that employers that have traditionally played an active role in the market be able to continue to operate their own plans. This means the ability to remain self-insured, to benefit from our own experience rating, and to enter a market of multiple purchasers, where price and quality are driven by market factors rather than government entities or rules. It means that multi-State self-insured companies providing uniform nationwide benefits for their employees must be free from State regulation or State control under a single-payer plan.

If the reform market is truly employer based with employers and employer groups actively managing plans, members of the coalition accept an employer mandate as necessary to extend coverage and distribute cost equitably.

The coalition does not come to this position easily. Our companies want as much flexibility as possible to respond to our market

conditions and to manage our costs. Nothing makes our companies more uncomfortable than the prospect of being required to provide specified health benefits indefinitely. We recognize, however, that health care does not follow normal economic rules.

An employer-based system cannot work if individuals have unlimited access to health care, but only those employers who volunteer finance that care. If the use of care is not going to be tied to the payment of care, there is a classic free rider problem.

Our companies now pay approximately a 30 percent surcharge on our health benefits to financial care for people who are not our employees and this surcharge is growing as coverage continues to climb.

This cost shifting problem is not solely a problem for large employers. Three-quarters of small employers, other than the very smallest, provide coverage and pay the surcharge as well. Some large companies contribute to the problem. There are as many uninsured people working for the largest companies as there are for the smallest.

There is a legitimate concern in Congress about job loss from an employer mandate. We recognize that to the extent that companies cannot pass along these higher prices or lower wages there will be some short-term dislocation.

Some people suggest we should try to expand coverage without a mandate. We believe efforts to expand voluntary coverage would be costly and ineffective. We urge the committee to review the many demonstration projects that have attempted without success to expand coverage by providing direct subsidies and purchasing groups to small employers. In addition, proceeding with insurance reforms like guaranteed issuance and community rating in the absence of a mandate may well chase the good risks out of the market and increase the number of uninsured.

A system that is going to continue to be largely financed and operated by employers cannot work if the employers can choose whether to participate in financing. A market made up of multiple purchasers, with Federal preemption, can accommodate an employer mandate. On the other hand, if employers cannot manage their own plans, remain active purchasers of care, and control their own health care costs, an employer mandate is an unacceptable way to finance expanded coverage.

Mr. JACOBS. Sir, I am sorry I am afraid your 3 minutes have expired.

[The prepared statement follows:]

**STATEMENT OF MICHAEL R. BECKER
ON BEHALF OF
CORPORATE HEALTH CARE COALITION**

Mr. Chairman and Members of the Committee:

My name is Michael R. Becker. I am Vice President - Benefits for the McDonnell Douglas Corporation. I am here today on behalf of the Corporate Health Care Coalition, a group of large, self-insured, multi-state employers, recently formed to support the enactment of health care reform legislation. At present, the Coalition has -- member companies -- all Fortune 200 -- who operate health plans for employees, their families, and retirees, covering over 3.2 million lives (1.26% of the U.S. population) and providing more than \$7 billion per year in health benefits. Each of our members has a sufficient employee population to qualify as a Corporate Alliance under the President's health care reform proposal.

Our Coalition is distinguished by its exclusive focus on issues of significance to large, self-insured employers. Our primary health care concerns are those of purchasers of health care for our employees and not those of vendors of insurance or health care products. Members of the Corporate Health Care Coalition have been in the forefront of efforts to ensure high-quality and cost-effective benefits for employees. We have extensive experience in designing, administering, and delivering employee health benefits; and are a major force today in ongoing efforts to restructure the health care delivery system.

SUPPORT FOR HEALTH CARE REFORM

As a Coalition, we are committed to the enactment of a comprehensive health care reform plan consistent with our principles by the end of 1994. We are pleased that the Congress is making progress toward that end and commend the President on his leadership in drafting and introducing a detailed reform proposal.

Our support for health reform is based on our belief that, properly designed, reform can improve access and control costs while enhancing the quality of care. To do this, we think health care reform must:

- slow the growth in health care costs;
- ensure that employers are responsible for their own employees;
- finance additional community health care costs where necessary through broad-based taxes;
- promote a continuing movement toward organized systems of care;
- rely primarily on private market mechanisms to restructure the market; and
- reduce inefficiencies and waste in the current system.

We believe a reformed health care system needs to retain a role for large employers who choose to continue providing health benefits for their employees. This role is necessary both as a source of continuing innovation in the system and as a benchmark against which to measure the performance of reforms in the rest of the system. Let me be clear that member companies of the Corporate Health Care Coalition support at the very highest levels of the companies a continuation of employer-provided health benefits. Our employees and shareholders are not prepared for us to simply write a check to some third party to provide health benefits for our employees.

For an employer-based system to work, we believe the following elements of the health care system are necessary:

- a requirement that all employers participate in financing health care for their employees and that all individuals enroll in plans;
- a marketplace with multiple purchasers of health care services, including a continuing role for large employers as purchasers;

- small employer purchasing groups that lower costs for small employers and that remain small enough themselves to avoid dominating the market;
- separate rating of large purchasers to enable purchasers to benefit from active management of their plans;
- national standards for employer-based plans (as now under ERISA) to allow uniform operations across state lines;
- an end to cost shifting from underfunded public programs, like Medicaid and Medicare, to private purchasers.

The Coalition has reviewed the various reform proposals, including the President's, and concluded that we support some aspects of each of the major pieces of legislation, but no single bill in its entirety. Specifically, we support provisions that would:

Encourage a restructuring of the health care delivery system with a growing emphasis on organized systems of care and a greater reliance on primary and preventive care;

Enable large corporate purchasers to play an active role in purchasing and managing health coverage for their employees, and benefit from these efforts through experience-rated premiums;

Enable multistate employers to operate uniform benefit plans for employees under nationwide guidelines without regulatory interference from 50 states, or abrogation by state single-payer systems;

Extend health insurance coverage to nearly every U.S. resident, improve the availability and affordability of health insurance to small business and individuals through insurance market reform and pooled purchasing, and require employers to participate in financing health benefits for their employees;

Simplify health insurance by creating a standard benefit package with continuity of coverage and uniform electronic claims processing; and

Adequately finance the expansion of coverage through overt, broad-based measures without shifting a greater share of the financing burden to corporate purchasers.

THE EMPLOYER ROLE

As employers, we have been increasingly active in recent years in organizing health care for our employees, to ensure them a high quality of care at a reasonable cost. Our major goal in reform is to strengthen the role of employers -- individually and through purchasing groups -- in managing health care costs and quality.

Coalition member companies function today not just as knowledgeable purchasers but as active shapers of the health care delivery system and marketplace. Our companies encourage preventive care and educate employees on the appropriate use of care. We structure financial incentives to encourage employees to enroll in the most cost-effective plans. Some of our companies have initiated efforts to measure and report on provider quality and to use that information as the basis for assembling networks of cost-effective, high-quality providers. We case manage severe illnesses or injuries and ensure our employees receive the best care at reasonable cost. Finally, we use our purchasing power not solely to lower rates but to influence practice parameters, and ultimately the utilization of services.

We are struck by the similarities between some of the innovative projects our member companies are implementing and what health care reformers would like to

extend to the rest of the population. We believe this fact alone stands as testimony to the important role that employers can play -- individually and in groups -- as innovators and problem solvers in our health care system.

We believe employers and groups of employers can operate effectively as multiple purchasers in the market to drive the health care system to more cost-effective results. For this approach to work the market needs to be diverse and not dominated by one or two large purchasers, it must be influenced by aggressive purchasing and not by artificial, government-imposed constraints, and it must be relatively free of excess state or federal regulatory interference.

We accept the fact that if there is a truly employer-based health care system, with the market structure, ERISA protections, and financing necessary to make such a system work, it is logical to require all employers to participate in that system.

EMPLOYER MANDATES

As you know, the President's proposal would require every employer to contribute 80 percent of the average cost of a health plan premium for every full-time employee, and a pro-rata share of that amount for every part-time employee. The President has made it clear, most recently in the State of the Union message last week, that universal coverage -- health care security for every American -- is his bottom line for signing a health care bill this year. At the same time, some Members of Congress have made it equally clear that they cannot support a bill that mandates coverage for anyone. The lines on this issue seem clearly drawn.

There is no issue that is more painful or more divisive for the business community than this question of employer responsibility to finance health care for employees. No business wants to see Congress mandate additional business responsibilities. Businesses want as much flexibility to manage their costs as is possible to successfully respond to changes in the marketplace and to survive in an increasingly competitive global economy. The last thing any of us wants is to hitch a major element of our labor costs -- health care benefits -- to a cost escalator and turn over the operation of it to the Federal Government.

I feel particularly uneasy about health care mandates because no single entity -- business, government, or provider -- has yet demonstrated any success in slowing the growth in total health care costs. Once there is a mandate to pay for 80 percent of a specified benefit, our company will have a reduced capacity to limit our own health care expenses without a systemwide solution that slows the total health expenditure growth.

This is not a simple issue, though. While many businesses may be inclined to "just say no" to employer mandates of any kind, I think we must look more carefully at mandates for health care. Health care is unlike any other benefit we provide as a company, and therefore cannot be lumped with other activities in our thinking.

While employers now have the choice of whether or not to finance health insurance for their employees, they do not directly affect their employees' use of health care. Those employers who do not offer health benefits do not prevent their employees from consuming health care, they simply deflect the bill for that consumption to someone else. Consumption of health care is assured, while payment for it is voluntary. We have what economists call a massive "free-rider" problem. If it is possible to get care without paying, there is a strong disincentive to pay for it. In most other forms of insurance, if you do not have it and a disaster strikes, you lose everything. A workable insurance mechanism requires either that people without insurance be denied care or that everyone have health insurance. If we stay in the middle, we can only expect to see the current decline in health insurance coverage continue at an accelerating rate -- 1 million more uninsured a year in 1990 and 1991, growing to 2 million more in 1992 alone.

We really cannot afford to stay where we are -- where we are is not working. With every passing day, the incentives grow for companies to drop their health benefits.

Small employers are being driven out of the system the most rapidly -- in 1992 alone, the percentage of small firm (25 and under) employees without health insurance grew by 2 percentage points -- from 29 to 31 percent^{1/}. A continuation of this trend through the 1990s could result in a massive cost shift to employers who do cover their employees.

There are a number of arguments on both sides of the employer mandate debate. I would like to discuss a few of them today in the rest of my testimony.

Costs

An employer mandate is a two-edged financial sword for business -- it both increases and decreases costs. Companies that have had substantial health insurance coverage should have their costs lowered by an employer mandate. Those without coverage will clearly have their costs raised. Most of this will simply undo the current cost shift, but there may be some added cost to business in the aggregate resulting from the overall expansion of health insurance coverage.

Undoing the cost shift

We are only now beginning to develop some reliable numbers on the amount of cost shift to companies with health benefits. A 1991 study by Lewin/ICF estimated that cost shifting increases the health benefit costs for companies with more than 1,000 employees by 33 percent when all sources of cost shifting are considered. Lewin estimated that an employer mandate would eliminate 75 percent of this cost shift^{2/}.

The Lewin/ICF study probably underestimated the amount of cost shift to large companies. Uncompensated care for the uninsured alone costs about 10 cents of every dollar of hospital payment.^{3/} Another 14 cents compensates for hospital shortfalls from Medicaid and Medicare^{4/}. And more than 20 percent of large employer benefit costs is attributable to spouses and dependents who would be covered under other employer plans with an employer mandate^{5/}. The effects of an employer mandate will be company specific. On average, however, we believe that the reduction in cost shifting from a mandate would save the average large company about one-third of their current health benefit costs.

Coverage is not a big company/small company issue. Many of the workers who are not now covered work for the largest companies. EBRI estimates that one-fourth of all uncovered workers (4.4 million) are in firms with 1,000 or more employees. This is equal to the number of uninsured (4.6 million) who work in the smallest firms (under 10 employees).

In fact, a large proportion of small businesses have as much of a stake in universal coverage as large employers. More than three-quarters of small firms (except the very smallest) now provide health care to their workers (see table below). These firms pay for the their own workers plus the uninsured and would benefit significantly from having their competition contribute for health care as they do.

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1. Employee Benefits Research Institute. Sources of Health Insurance and Characteristics of the Uninsured. Special Report and Issue Briefs # 133 and 145. January 1993 and 1994.
 2. Donald Moran and John Shiels. Employer Cost-Shifting Expenditures: Final Report. Prepared for the National Association of Manufacturers. Washington: Lewin/ICF. September 12, 1991.
 3. Based on estimates of hospital cost shifting in 1990 prepared by the Prospective Payment Assessment Commission (ProPAC).
 4. Ibid.
 5. Based on a analysis conducted by the Wyatt Company of 70 large company plans.

Firms Offering Health Benefits and Employees With Employer Premium Contribution, by Firm Size*

Firm size	Finances benefits (1990 data)
Fewer than 10 employees	27%
10 to 24 employees	73%
25 to 49 employees	85%
50 to 99 employees	89%
100 or more employees	98%

from HIAA: Source Book of Health Insurance Data, 1991

Raising Coverage Levels

The level of employer contributions that are mandated is a major factor influencing the net savings or costs to employers. A requirement that employers finance 80 percent of the cost of a comprehensive benefit package is fairly consistent with benefits now provided by most large companies, but would have the effect of raising costs for some small and medium size employers who now finance a smaller share of the premium or provide a less-comprehensive package of benefits.

Increased Utilization

Another factor that may increase costs for employers who already provide benefits is the effect on overall health care costs of induced demand among the population that had no coverage previously. Any approach to universal coverage will cause an increase in the use of medical services, and a resulting increase in the overall cost of the system. The real issue for employers is whether the net effect of financing this increased demand is less through an employer mandate than it would be through payroll, sales, or corporate taxes. In most cases, employers who have traditionally provided coverage will be less affected through an employer mandate than they would be through tax-based financing for expanded coverage.

The Need for Subsidies

Some amount of subsidy for business and individuals may be necessary to cushion the economic effect of the transition from partial to universal coverage. The financing of subsidies has the effect of reducing the benefit employers with coverage receive from a reduction in the cost shift. The greater or more broadly provided the subsidy, the less significant the savings from reducing the cost shift. At some level of subsidy, the subsidy simply recharacterizes the cost shift. Short-term subsidies that are highly targeted to the groups most affected by the mandate may be necessary to allow employers who have provided coverage to gain sufficient benefit from the employer mandate.

The Impact on Jobs

There is a great deal of concern about the impact an employer mandate may have on labor costs for small employers and the possible loss of jobs that may result. Given that nearly all uninsured workers are low-wage workers -- 85 percent of those without coverage earn less than \$20,000 a year⁶ --, mandatory health benefits will raise the cost of an uninsured worker substantially -- by 10 percent or more.

The impact of this cost increase on jobs will vary depending on the industry a firm is in, its labor and product markets, and the nature of its competition. In some cases, employers will be able to reduce or hold down wages to compensate for health benefit costs. In most cases, because all of a firm's competitors will have the same mandate, companies should be able to pass the added cost on through price increases to

6. EBRI, 1994.

consumers. Only in those industries where consumers may be motivated by price increases to curtail consumption or substitute products outside the industry and where wages cannot be reduced will employers be forced to cutback on the number of workers.

Loss of jobs will certainly occur, and the dislocation it could cause for workers in the affected industries should not be understated. From a broad economic perspective, however, a mandate could also create jobs by reducing distortions in the market caused by the inequitable distribution of health costs. For example, a mandate can reduce the competitive disadvantages small companies with health benefits face from companies without health benefits. Furthermore, our globally competitive manufacturing sector would no longer bear the health costs of our nation's service sector, where many employees consume care not paid for by their employers or by themselves.

Achieving Universal Coverage without a Mandate

One proposed alternative to the employer mandate is to reduce health insurance costs and provide subsidies to encourage small businesses to adopt health insurance for their employees voluntarily. Voluntary coverage has been the subject of much state experimentation, and a number of states -- most notably California, Florida, and Minnesota -- have recently initiated projects aimed at luring small businesses into providing coverage. Results are not in from these most recent projects. Results from earlier projects, however, have been disappointing. If there is one simple conclusion that can be drawn from the array of past demonstration projects, it is that no approach has yet been effective in inducing small businesses without coverage to adopt health insurance for their employees.

Three different sets of projects all have generated the same conclusion. One is a group of fifteen state-level projects funded by the Robert Wood Johnson Foundation in 1986 to develop innovative financing and services to stimulate the adoption of health insurance by small businesses. The seven surviving small-business-oriented projects, evaluated by the Alpha Center in March 1992, had enrolled, on average, only 4 to 6 percent of the target market of uninsured small businesses after two to three years. The projects used various combinations of pools, marketing and administrative savings, provider negotiation, scaled-down benefit packages and direct subsidies ranging from 10 to 60 percent of premium. The most successful project -- MaineCare, which provided a 60 percent subsidy -- managed to enroll only 17 percent of the uninsured small businesses⁷.

A pilot project in New York where the state offered to pay 50 percent of the premium to specific HMOs for firms with 20 or fewer employees without insurance was similarly unsuccessful. A study of the project's effect after one year determined that the subsidized insurance accounted for an increase of only between 0.6 and 3.5 percentage points in the proportion of small firms providing insurance. More than one-quarter of the small firm owners surveyed stated that they had little or no interest in purchasing insurance at any price either because their employees already had coverage through a spouse's employer or because the available plans did not interest them⁸.

Finally, 24 states have enacted laws that permit the sale of "no frills" or "bare-bones" insurance policies in an effort to make insurance more affordable for small businesses and individuals. As of December 1992, products were available in 11 states. An analysis by Blue Cross and Blue Shield of the response in those 11 states revealed a similar lack of interest in voluntary coverage. In general, premiums for bare-bone policies were 20 to 40 percent lower than premiums for traditional policies. Yet, in

7. David W. Helms, et al. "Mending Flaws in the Small-Group Market," *Health Affairs*, Summer 1992, pp. 9-12.

8. K.E. Thorpe, et al. "Reducing the Number of Uninsured by Subsidizing Employment-Based Health Insurance: Results from a Pilot Study," *Journal of the American Medical Association*. (267:945-948) February 19, 1992.

seven of the states, Blue Cross and Blue Shield had enrolled a total of only 1,746 members. Nearly all of the 46,457 enrollees were in four states, three of which were the only states permitting persons with insurance to switch to a bare-bones plan. Seventy percent of those enrolled were young families and single adults in a single state who appeared to have been enticed to switch from other health plans by the lower premiums available through the bare-bones plan⁹.

It is hard to come to any other conclusion from these studies than that we have not yet found any combination of conveniences and subsidies that can encourage large numbers of the uninsured to adopt health insurance coverage voluntarily.

Insurance Market Reform and Mandates

Some people have suggested that the Congress should reform the health insurance market for small business and individuals and see if that will encourage a voluntary expansion of health insurance coverage before Congress proceeds to mandate coverage. Requirements that health insurers guarantee issue to all applicants, guarantee renewability, cover pre-existing conditions, and community-rate premiums would certainly make coverage available at a reasonable price to high risk businesses and individuals. Many small firms and individuals who have been unable to purchase insurance in the past would buy coverage under these conditions. Would this result in a net increase in health insurance coverage?

Health insurance reform without a mandate would most likely have the reverse effect. It would drive people out of the insurance market and increase the numbers of uninsured. This loss of coverage would follow from what insurers call "the death spiral." First, insurers would be required to cover all applicants and charge everyone the same premium no matter what their health status. Those firms and individuals with low health risk (e.g. young families and single adults) would lose their low experience-rated premiums and be charged a much higher community-rated premium. For some, these premiums could be nearly double their current premiums. Without a mandate, some low-risk firms and individuals will drop coverage, raising the average premium for those remaining, driving out more good risk, and pushing the premium still higher. The number of uninsured will increase, and with it the volume of cost shifting. Even though those leaving the system will have less health risk, many of them will still need health care at some time, shifting their uncompensated care costs to others.

New York's new community rating law, enacted without a mandate, should provide sufficient evidence that this combination of insurance reform and no mandate can be disastrous. Hefty premium increases resulting from community rating have already driven a large proportion of previously-insured individuals out of the system. As a result, another round of premium increases may be in the works.

Individual versus Employer Mandates

The President's reform proposal calls for both an individual and employer obligation to pay for insurance coverage. Some reform proposals, however, would only require individuals to purchase health insurance. Can universal coverage be as easily achieved through an individual mandate alone?

An individual mandate has the advantage of financing coverage directly from the individual's wages rather than financing it indirectly through the employer and putting jobs at risk. The individual mandate would make individuals more responsible for their own insurance coverage, and more focused on getting the most reasonably-priced plan.

9. S.S. Laudicina, "Impact of State Basic Benefit Laws on the Uninsured." Blue Cross and Blue Shield Association, December 1992.

There are two major concerns with an individual mandate: whether it is feasible to force individuals to purchase health insurance, and whether an individual mandate can be enforced.

The uninsured tend to have very low incomes -- 88 percent were in families with adjusted gross incomes below \$20,000 in 1992¹⁰. To make it possible for individuals to reasonably afford health insurance premiums ranging from \$2,400 to \$6,000 a year, there would need to be substantial government subsidies for the vast majority of uninsured individuals, financed through significant new taxes. Assuming that businesses can pass much of the cost on to consumers rather than take it out of workers' wages, and recognizing that a large portion of the uninsured work for companies that already cover some of their workers, an employer mandate requires a much lower level of government subsidy to make it work.

An individual mandate also requires a much more intrusive and intensive enforcement mechanism to attain nearly universal coverage. All employers already withhold social security taxes and meet other federal employment requirements that are enforced through the Department of Labor and the Internal Revenue Service. A large number of individuals, however, particularly those with low incomes, do not currently file tax returns or come into contact with federal regulatory agencies. As a result, enforcement of an individual mandate would have to be much more aggressive in searching out and prosecuting individuals who failed to comply than would enforcement of an employer mandate. A more passive enforcement strategy -- waiting until people were hospitalized to sign them up for health insurance -- would only encourage a continuation of the patterns of utilization that have already proven to be expensive for the system.

Finally, an individual mandate does nothing to reduce the cost shift from employers who provide health benefits to those who do not. Individuals will be able to meet the requirement for coverage by opting into their spouses' plans. As a result, an individual mandate would fail to address some of the inequities in cost distribution that currently reduce our international competitiveness.

CHCC Position on an Employer Mandate

A requirement that employers participate in financing health benefits for their employees is an inherently unnerving and unpleasant prospect for employers. Most employers now voluntarily finance health benefits for their employees, but they do so in the context of maintaining full discretion over the contents of the benefit package, the operations of the plan, including relationships with health care providers, and, ultimately, plan costs. An employer mandate brings with it not only the obligation to finance benefits, but significant new restrictions on the ability to modify benefits or contribution levels in order to manage costs.

For this reason, it is particularly important that employers who have traditionally played an active role in designing, organizing, managing, and self-insuring their health plans be able to maintain a substantial role in operating their own plans in the future. Multi-state, self-insured companies that have traditionally provided uniform nationwide health benefits for their employees must also continue to be able to operate these plans without interference from the states, either through state regulation of the plans or state establishment of single payer plans that apply to their employees. Corporate alliances or other vehicles that permit employers to continue operating their own plans must be restructured as a viable option.

In the context of an employer-based system of coverage, with employers continuing to play an active role in operating health plans for employees, members of the Corporate Health Care Coalition are prepared to accept an employer mandate. Any mandate would have to be carefully drawn so that an employer would bear responsibility only for actual employees and not, for example, for independent contractors. We believe

10. EBRI, 1994.

that a system that is going to continue to be largely financed by employers cannot work if the employees have a right to care, but employers can choose whether to participate in the financing. This kind of structure inevitably hemorrhages insurance coverage, inevitably shifts costs from low value to high value producers, and inevitably self-destructs as a fair and reasonable way to finance health care. The failure to create a viable employer-based system may force the country to ultimately reject the role of employers in favor of a tax-financed and government-run national health program. We believe that an employer-based system can more effectively meet the needs of our employees.

AlliedSignal Inc.
 Ameritech
 Amoco Corporation
 Atlantic Richfield Company
 Bell Atlantic
 The Boeing Company
 Cox Enterprises, Inc.
 Dow Chemical Company
 DuPont Company
 General Electric Company
 Hershey Foods Corporation
 Intel Corporation
 International Business Machines Corporation
 McDonnell Douglas Corporation
 Pacific Telesis Group
 Ryder System, Inc.
 Southwestern Bell Corporation

Mr. JACOBS. Congressman Hilliard, I think, wanted to introduce Mr. Richey, so I will be happy to stand in for him and introduce him, introduce you to us.

STATEMENT OF VAN L. RICHEY, PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMERICAN CAST IRON PIPE CO., BIRMINGHAM, ALA.

Mr. RICHEY. Thank you, Mr. Chairman.

Mr. JACOBS. We apologize.

Mr. RICHEY. My name is Van Richey. I am the president and chief executive officer of ACIPCO in Birmingham, Ala. The manufacturing of pipe and valves is our primary business of ACIPCO, which by the way, stands for American Cast Iron Pipe Co.

I describe ACIPCO in greater detail in my statement. We are a private company beneficially owned by our employees and have been since 1924.

With a \$100 million payroll, we are the largest manufacturing employer in the Birmingham area. ACIPCO has 3,400 employees with 2,700 at our headquarters operation. We have labor representatives on the board of directors and, yes, they are voting representatives.

ACIPCO has been selected by the author of a book entitled, "The 100 Best Companies to Work for in America," as among one of the 15 best places to work in America. They note that we have our own health care clinic in our plant in Birmingham, with 8 full-time physicians on staff, along with 5 full-time dentists and 24 contract medical specialists to care for our employees, retirees and their dependents, which number some 10,000 people.

We built our 35,000-square-foot medical facility in 1988 for \$3.5 million to keep pace with our ever-increasing health care needs. It replaced a facility built in 1923. The facility has more than 60 employees serving 200 people a day, a third of them children.

I would like to briefly address two parts of the President's health security plan, employer-mandated coverage and the proposed regional alliances. We believe that every employer should have some responsibility to provide health care benefits for its employees. Currently, we are aware of employers who are compensating their employees who happen to be spouses of our employees, to drop that employer's coverage so that we bear full responsibility for that family. This is not an equitable system and could be substantially improved through some type of employer-mandated coverage. Presently, my company is being forced to subsidize another employer's health care costs.

The proposed regional alliances would force our company to join a regional alliance, resulting in likely reduced benefits, which we oppose. We urge Congress to preserve the medium-sized corporate autonomy in health care delivery as we believe many other companies have shown success in delivering a quality and cost-contained program.

We are encouraged to learn that the administration may be considering lowering the employee threshold for regional alliances. We applaud this modification. As I trust you will realize, our company is serious about providing quality health care benefits to all of our employees, retirees and their family members. We believe our system works and would like to have our program used as a model for American business to emulate.

Thank you, Mr. Chairman.

Mr. JACOBS [presiding]. Thank you, Mr. Richey.

[The prepared statement follows:]

**STATEMENT OF VAN L. RICHEY,
PRESIDENT AND CHIEF EXECUTIVE OFFICER
AMERICAN CAST IRON PIPE COMPANY
Before the Committee on Ways and Means
U.S. House of Representatives
February 3, 1994**

I appreciate this opportunity to address your Committee. My name is Van L. Richey, and I serve as President and Chief Executive Officer of ACIPCO in Birmingham, Alabama. The manufacturing of pipe and valves is our primary business at ACIPCO, which, by the way, stands for American Cast Iron Pipe Company.

Acipco is a private company and, while our sales figures are confidential, we are among the strongest companies in our industry. ACIPCO was founded in 1905 and is one of the oldest companies in the State. We are the largest manufacturing employer in the Birmingham area. Our company has 3400 employees, including 2,700 at our headquarters operation. Our Birmingham facility now consists of more than 2,000 acres and measures three miles from end to end. ACIPCO's annual payroll is \$100 million.

We have four divisions. Our American Ductile Iron Pipe Division manufactures ductile iron pipe, which is sold worldwide. This division, which also makes ductile iron fittings, accounts for about half of our business and is our largest division. Our American Steel Pipe Division manufactures high-pressure steel pipe that is used in the oil and gas industries. Our American Flow Control Division produces valves, fire hydrants and pumps in Birmingham, Beaumont, Texas, and St. Paul, Minnesota. The American Centrifugal Division produces steel castings used in several capital goods markets.

Our largest facility is our Birmingham operation, and in addition to our plants in Texas and Minnesota, our Specification Rubber Products subsidiary in Alabaster, Alabama, produces gaskets and other rubber products for us, as well as other companies.

That, in a nutshell, is who we are and what we do. Now let me mention a few things that we believe set us apart-- that make us something special:

We are beneficially owned by our employees and have been since 1924. Not only do we want our people interested and actively participating in our company's day to day business; we think it is absolutely vital that they do so. We have labor representatives on the board of directors. And, yes, they are voting representatives.

ACIPCO was recently among 100 companies included in a best selling book entitled "The 100 Best Companies To Work For In America." In fact, the authors of that book put us among the 15 best places to work in America.

Criteria for selection in the book included pay and benefits; career advancement opportunities; job security; work force pride; openness and fairness between management and employees. Only a small percentage of companies were included in the top 100, much less the top 15, so I believe our inclusion on this list sets us apart from most other businesses.

One of the things the author notes in the "The 100 Best Companies To Work For In America" is that we have our own health care clinic at our plant in Birmingham with eight full time physicians on staff, along with five full time dentists and 24 contract medical specialists to care for our employees, retirees and their dependents. We built our 35,000 sq. ft. facility, which has more than 60 employees, in 1988 for \$3.5 million to keep pace with our ever increasing health care needs. It replaced a facility built in 1923.

Our health care clinic-- which includes medical, dental and pharmacy departments-- is a good example of something that sets us apart. We are one of only two corporate outpatient care centers meeting the critical standards of the nations top health care accrediting agency. Our clinic was accredited by the Joint Commission on Accreditation of Health Care Organizations in 1991.

In "The 100 Best Companies To Work For In America" the authors point out, and I quote, "ACIPCO provides what is arguably the best and most comprehensive employee health care coverage of any company in America." Our health care facility sees more than 200 people a day--a third of them children. In all, this facility is open to 10,000 people--Acipco employees, retirees and their families, including spouses of deceased retirees. Our employees get a 75 percent discount on prescription drugs and pay only 15 percent of the doctor's fees when referred to an outside specialist. We pick up the rest, including 100 percent of all hospital bills. Our Birmingham health care costs in 1992 were more than 15 million dollars. ACIPCO health care cost increased less than 2% in 1992 compared to 1991: and less than a 6% average over the last five years.

We contain our health care costs by employing several techniques:

1. Patient education--our ACIPCO patients participate in cost sharing and understand that an informed patient will help us to eliminate unwarranted health care expense.

2. Physician participation-- involvement of our eight physicians is required to continue medical education through seminars, publications, and by participating in closed circuit television programs, which are available throughout our clinic. In addition, the physician's health care delivery is monitored through measurement of patient outcomes.

3. Pharmacy and Therapeutics committee-- this committee provides an evaluation of current and prospective drug utilization with an emphasis on generically equivalent medicines which provide efficacy at less cost. This committee also has a responsibility of developing the formulary used by our physicians in prescribing medications.

4. Health Care Management--we manage our health care costs by contracting services with outside physicians, physical therapists, durable equipment providers, and designated hospitals. We have established specialist pathway referrals and have assigned case managers during and after hospitalization to promote home care with early hospital discharge planning. Our staff monitors outpatient care and goal attainment in physical therapy.

5. Risk management-- we strive to maintain a close liaison with our medical liability carriers and follow their recommendations to obtain least costly malpractice and facility premiums.

6. Capitation--we have contracted a maximum cost for mental and nervous benefits and physical therapy charges to include work-hardening and rehabilitation.

7. Wellness program--we have begun a wellness program to provide patient education and encourage changes in lifestyle to promote good wellness habits. Our wellness director has established screening and assessment programs, which include weight loss, smoking cessation, stress management and physical conditioning.

I would, however, like to briefly address two parts of the President's Health Security Plan-- the employer mandated coverage and the proposed regional alliance.

We believe that every employer should have some responsibility to provide health care benefits for it's employees. Currently , we are aware of employers who are compensating their employees, who happen to be spouses of our employees, to drop that employer's coverage so that ACIPCO bears full responsibility for that family. This is not an equitable system and could be substantially improved through some type of employer mandated coverage. Presently, my company is being forced to subsidize another employer's health care costs.

The proposed regional alliances would force our company to join a regional alliance, which we oppose. We urge Congress to preserve the medium-size corporate autonomy and health care delivery, as we believe many other companies have shown success in delivering a quality and cost contained program. We are encouraged to learn that the administration may be considering lowering employee threshold for regional alliances. We applaud this modification.

As I trust you will realize, our company is serious about providing quality health care benefits to all of our employees, retirees, and their family members. We believe our system works and would like to have our program used as a model for American business to emulate.

I appreciate this opportunity to provide my company's concerns and suggestions for equitable and efficient implementation of the potential changes for health care delivery in our country. I will be pleased to answer any questions you may have.

Mr. JACOBS. Mr. Williams.

STATEMENT OF ANTHONY C. WILLIAMS, DIRECTOR, RETIREMENT, SAFETY AND INSURANCE DEPARTMENT, NATIONAL RURAL ELECTRIC COOPERATIVE ASSOCIATION

Mr. WILLIAMS. Thank you, Mr. Chairman. My name is Tony Williams. I am the director of the retirement, safety and insurance department of the National Rural Electric Cooperative Association. NRECA is a national service organization representing approximately 1,000 rural electric cooperatives operating in 46 States.

NRECA has for many years been deeply interested in health care policy, and we applaud President Clinton's commitment to reforming the health care delivery and financing system. The administration's proposal is a vital first step in addressing the problems that exist in this critical area.

I am testifying here today regarding NRECA's reaction to the idea of corporate alliances as set forth in the administration's proposal. But before turning to that subject, I would like to briefly digress.

Perhaps the greatest challenge facing Congress and the administration with respect to health care reform is how to make reform work in rural areas. Rural areas share the problems encountered by urban areas, but in addition, they face even bigger problems in providing adequate resources and adequate infrastructure and personnel to provide medical care.

We urge Congress and the administration to continue to seek ways to solve these critical problems, and in that respect, we pledge our assistance.

We agree with the administration that there should be corporate alliances. First, the employer has a far greater interest in the health and morale and productivity of his employees than does any State-certified health plan or State-established regional alliance.

Second, an employer knows his employees better than any unrelated third party and is thus better suited to design a plan to meet his needs.

Third, any health care system should encourage establishing wellness programs and encourage innovation in all areas, including cost-containment and quality of care.

The corporate health alliance creates tremendous incentives for such improvements by putting control in the hands of those who would benefit most from those improvements. However, our ability to exercise the corporate health alliance option, we believe is tempered by severe disincentives included in the administration's proposal. There are significant Federal subsidies applicable to regional health alliances which do not apply to corporate health alliances.

Second, I would like to highlight the 1 percent of payroll assessment. Originally, all corporate alliance sponsors were subject to a tax equal to 1 percent of payroll. That provision has now been changed for multiemployer corporate alliances. In contrast, though, regional alliance employers are indirectly assessed an amount equal to 1.5 percent of health insurance premiums.

Finally, corporate alliances would be made up of small employers that would otherwise be eligible for a variety of Federal subsidies that are available to each employer operating a regional alliance. We believe that unfair playing field should be changed so that our employer-members would not be significantly disadvantaged.

Thank you, sir.

[The prepared statement follows:]

**STATEMENT OF ANTHONY C. WILLIAMS
NATIONAL RURAL ELECTRIC COOPERATIVE ASSOCIATION**

Introduction

Mr. Chairman, my name is Anthony C. Williams and I am the Director of the Retirement, Safety, and Insurance Department for the National Rural Electric Cooperative Association ("NRECA"). We are pleased to have this opportunity to share our comments regarding the treatment and operation of corporate alliances, as described in the Administration's health reform proposal.

NRECA

NRECA is the national service organization of the approximately 1,000 rural electric service systems operating in 46 states. These systems serve over 25 million farm and rural individuals in 2,600 of our nation's 3,100 counties. Various programs administered by NRECA provide pension and welfare benefits to over 125,000 rural electric employees, dependents, directors, and consumer members in those localities.

NRECA has for many years been deeply interested in health care policy. In this regard, NRECA has sponsored studies such as "Health Care Needs, Resources and Access in Rural America", "The NRECA Survey of Health Coverage in Smaller Firms", "The NRECA Plans and the Minimum Health Benefit", and "Managed Care Plans in Rural America". NRECA is currently updating "Health Care Needs, Resources and Access in Rural America", for distribution in late January or early February of 1994.

Our studies of health care financing and delivery systems in rural areas have given us an appreciation for the complexity of these issues. We recognize that we are still learning about health care reform and the possible means of transforming our current health care system. We also are still learning from NRECA members about their views on these important issues. Accordingly, we anticipate modifying and refining our views as the reform process moves forward.

We applaud President Clinton's commitment to reforming the health care delivery and financing system. The Administration's proposal is a vital first step in addressing the problems that exist in this critical area.

Corporate Alliances - In General

We are testifying here today regarding NRECA's reaction to the idea of corporate alliances as set forth in the Administration's proposal. Before turning to that subject, however, we would like to digress briefly. Perhaps the greatest challenge facing Congress and the Administration with respect to health care reform is how to make reform work in rural areas. Rural areas share the problems encountered by urban areas but in addition face even bigger problems: inadequate resources, infrastructure, and personnel to provide medical care. We urge Congress and the Administration to continue to seek ways of solving these critical problems. In that respect, we pledge our assistance based on our experience in rural areas.

With respect to the issue for today, *i.e.*, corporate alliances, a brief description of the corporate alliance concept is appropriate as an introduction to a discussion of our reaction. Under the Administration's proposal, in general, employers and individuals purchase health coverage from state-certified health plans offered through regional alliances. A regional alliance is an entity established by the state to serve as an intermediary between the health plans, on the one hand, and the employers and individual insureds on the other hand.

There is an exception from this general structure for corporate alliances. Generally, there are three types of entities eligible to be a corporate alliance: a large employer with over 5,000 full-time employees, a multiemployer plan with over 5,000 active participants, or a group of rural electric or telephone cooperatives that provide health coverage to over 5,000 full-time employees. If such an entity elects to be a corporate alliance, the regional alliance system does not apply to the entity's full-time employees. Instead, the corporate alliance becomes responsible for the health coverage of such employees. The corporate alliance may design its own self-insured health plans or contract directly with one or more state-certified health plans. Thus, briefly stated, the corporate alliance system provides an employer with far more control

over the design and administration of the health plans provided to its employees than does the regional alliance system.

Should Corporate Alliances Exist?

The fundamental question is whether corporate alliances should exist or whether the regional alliance system should be exclusive. We agree with the Administration that there should be corporate alliances. The basic reason for this belief is simple. An employer has a far greater interest in the health, morale, and productivity of its employees than does a state-certified health plan or a state-established regional alliance. Accordingly, it is only logical that the employer, and not some unrelated third party, would be the most responsive to the needs of the employer's employees in designing and administering a health plan.

More specifically, an employer knows its employees better than any unrelated third party and thus is best-suited to design a plan to meet their needs. An employer's knowledge of its workforce is also important in shaping the most appropriate system of health plan administration. Moreover, an employer's interest in its employees' morale will result in a more responsive administrative system.

In addition, we believe that the nation's health care system should encourage the establishment of wellness programs and other means of improving health. The system should also encourage innovation in all areas including cost-containment and quality of care. The corporate alliance system creates tremendous incentives for such innovations and improvements by putting control of the system in the hands of those who will benefit the most from improvements: the employer and its employees. Putting control in the hands of distant third parties can only slow the rate of improvement in health plans.

We at NRECA want the best health care for our members and their employees, and we want it at an affordable price. It is in our interest to strive for those goals. The state-certified health plans and state-established regional alliances have far less incentive to make the same effort. Accordingly, we strongly support the Administration's proposal to allow us to form our own corporate alliance.

Corporate Alliance Disincentives

Our sense of our ability to exercise the corporate alliance option is, however, tempered by the severe disincentives included in the Administration's proposal. Unequal treatment between regional and corporate alliance status is evident in a variety of provisions. There are six specific areas that we would like to discuss to illustrate our point.

Employer-level caps: In general, under the Administration's proposal, employers are required to pay, on behalf of their employees, 80% of the average premium for health plans within their alliance. However, the Administration's proposal imposes a cap on the amount that employers participating in a regional alliance will be required to pay for health premiums on behalf of their employees. That amount is generally 7.9% of wages paid to employees, adjusted downwards to as low as 3.5% in the case of low-wage employers operating small businesses. Any excess premiums that would otherwise be due are paid for by the government. In sharp contrast, employers operating corporate alliances are subject to no cap whatsoever and receive no comparable government subsidy.

One percent of payroll assessment: The Administration's proposal directs all corporate alliance employers to pay a tax equal to 1% of payroll. By contrast, regional alliance employers are indirectly assessed an amount generally equal to 1.5% of health premiums. There is no apparent policy reason for this more burdensome treatment of corporate alliance employers. The policy underpinnings of this provision are even more uncertain since recent Administration modifications to the provision exempt multiemployer corporate alliances from the operation of the 1% of payroll requirement.

Family premium discounts: The Administration's proposal offers a federal subsidy for payment of the employee share of health premiums to employees with family adjusted incomes of less than \$40,000. On the other hand, the proposal directs employers maintaining a corporate

alliance for the benefit of its employees to pay for a similar subsidy, however in this case limited to employees earning less than \$15,000. We can discern no policy reason for this dissimilar treatment of low wage earners, and for the existence of a federal subsidy only in the case of employees participating in a regional alliance.

Reductions in cost sharing: With respect to individuals who are AFDC and SSI recipients or whose family adjusted income falls below 150% of the applicable poverty level, the Administration's proposal makes available reductions in the amount of deductibles, copayments, and coinsurance that the individuals would otherwise have to pay. These reductions are available only to individuals enrolled in regional alliances. This discriminatory treatment is compounded by the fact the subsidy is provided by the federal government. Similar reductions in cost sharing are not available to corporate alliance employees who would otherwise be eligible for the subsidy.

Involuntary termination of corporate alliance status: There are a number of situations in which an employer will permanently lose its corporate alliance status. For example, such status is lost permanently if it is found to be out of compliance with any requirement imposed by the proposal. Such status is also lost if certain cost containment targets are not attained. With respect to the same "offenses", regional alliances are subject to much less onerous penalties. We respectfully submit that less draconian penalties, like those applicable to regional alliances, should apply to corporate alliances.

In a similar vein, the rules should be clarified so that a rural electric or telephone cooperative that does not initially join a corporate alliance may do so at a later date. The use of permanent, irrevocable elections is inappropriate in the changing world of health care.

Corporate alliance status in single payer states: The Administration's proposal permits states which opt to move to single payer status to elect whether to allow corporate alliances that otherwise comply with federal requirements to continue to exist. We believe that allowing the individual states such authority ignores the valuable role that employers currently play and should be able to play in providing cost effective, well-designed health benefits to their employees. As discussed above, employers are in the best position to evaluate and serve the health insurance needs of their employees.

The unequal and inappropriate treatment of corporate alliances with respect to the six areas discussed above should be remedied. Moreover, as a general matter, all disincentives with respect to corporate alliance status should be eliminated. Employers currently play and will continue to play an important role in the health care system and their operation should not be hindered by unequal treatment accorded corporate alliances.

Tax Status of Health Benefits Trust

Finally, we would like to raise one issue peculiar to rural electric and telephone cooperatives. Under the Administration's proposal, regional alliances would be tax-exempt. Under Internal Revenue Code section 501(c)(9), a health benefits trust established by a large employer or multiemployer plan could also be tax-exempt. We believe that the Administration's proposal should clarify that a health benefits trust established with respect to rural electric or telephone cooperatives could also be tax-exempt under section 501(c)(9). It would be severely unfair for a rural electric or telephone corporate alliance to be the only alliance unable to use a tax-exempt trust to fulfill its duties.

Skimming Concern

The argument offered for certain unfavorable treatment of corporate alliances in the Administration's proposal is the so-called "skimming" concern. This concern is that an employer or group of employers will elect corporate alliance status only if such status will result in lower health care costs. Health care costs will generally be lower only if the employer's employees are, on the average, younger and healthier than individuals in the regional alliance system. Because premium costs within a regional alliance are uniform, *i.e.*, do not vary based on health risk, the employer with healthier employees would fare better on its own as a corporate alliance. Thus, the concern is that corporate alliances will "skim off" low-risk

individuals and leave the high-risk individuals in the regional alliance. This skimming would, in turn, cause regional alliance premiums to be higher than they would otherwise be.

We recognize the legitimacy of this concern. However, we respectfully submit that the proposal's "penalties" on corporate alliances, such as the first four items described above under Corporate Alliance Disincentives, bear no relationship to this concern. No provision in the proposal determines whether any skimming has occurred. No provision imposes a penalty proportionate to any skimming. Instead, the proposal simply provides a long list of penalties on corporate alliances.

As discussed above, we believe strongly that there are good reasons to form a corporate alliance other than skimming, *i.e.*, an employer's desire to design and administer its health plans in such a way as to be most responsive to the employer's employees. For example, in our case, the employees covered by NRECA's plan tend to be older and many encounter on-the-job hazards. In this light, it would be difficult to accuse NRECA of skimming.

Thus, we believe that in many cases a corporate alliance may not be skimming at all. In such cases, the proposal's array of penalties is simply inappropriate. In other cases, the effect of a corporate alliance election may be skimming, though often this result will be incidental to the employer's main objective, which is control over health plan design and administration.

In this light, we propose the following. The penalties on corporate alliances should be eliminated. Instead, there should be a single provision that would address the skimming problem directly. For example, there might be a mandatory reinsurance system in which all health plans participate. In this way, corporate alliance plans might share in the excessive risks absorbed by the regional alliances (and vice versa).

There may well be other more finely tuned means of addressing the skimming problem. We would support a full analysis of all such means. We oppose, however, the Administration's long list of unrelated penalties on corporate alliances. We reiterate our willingness to work with this committee in any way possible to modify the Administration's proposal, to create a level playing field that would permit employers acting as corporate alliances to design and administer health plans that are the best for their employees.

Mr. JACOBS. Mr. Pantos, I believe you are next.

**STATEMENT OF GEORGE PANTOS, WASHINGTON COUNSEL,
SELF-INSURANCE INSTITUTE OF AMERICA, INC.**

Mr. PANTOS. Thank you, Mr. Chairman. I am George Pantos, counsel for the Self-Insurance Institute of America. I appear today on behalf of the self-insurance industry, and want to note at the beginning that 2 out of 3 private employees and their dependents who receive health benefits today receive them through self-insured plans of all sizes, ranging from plans as small as 25 to the larger ones. As a matter of fact, the number of employees covered by smaller plans has tripled in the last 3 years; now it is about 25 percent, compared to 8 percent 3 years ago.

Over 100 million dependents and employees are covered under self-insured plans, and these plans pay out on an annual basis over \$100 billion. It is for this reason that we oppose the employer mandate, which will not only create job loss, but is unnecessary to resolve current health care problems and will eliminate many beneficial aspects of the current American health care system, which is an employment-based system.

At present, 88 percent of Americans have health coverage; 92 percent of those covered receive health benefits through their employer. In other words, the great majority of Americans just don't need an employer mandate. This includes nearly seven out of ten covered Americans who currently receive health benefits from employer-based self-funded group health plans. Stated another way, the vast majority of employers currently provide health benefit coverage to their employees on a voluntary basis and don't need an employer mandate to do so. Government action forcing small firms to buy health coverage for their employees won't make benefit plans more available and affordable; it will cost many of these employees their jobs. Evidence available in the form of polls and surveys indicates that even without health reform legislation, positive changes are already under way in the Nation's health care system.

The Consumer Price Index for medical goods and services has been dropping steadily. The dramatic increase in self-insurance underscores the cost-saving innovation in health care, and its financing is due in great part to employer involvement in the health system. This trend emphasizes there is no basis in fact for dismantling the entire employment-based infrastructure built up over the years and replacing it with a network of unproven health alliances.

Finally, Mr. Chairman, like most Americans, SIA members are very concerned about the U.S. health care system and support changes that will improve the system. At the same time, we concur with recent surveys which suggest that most American workers are satisfied with their employer-sponsored health benefit plans. While President Clinton is correct to identify economic problems such as soaring costs and lack of access, his reform plan, we believe, goes in the wrong direction. The President's call for more government involvement in the health marketplace is the wrong prediction for problems of cost and access and the employer mandate will only serve to exacerbate rather than resolve these problems.

Mr. JACOBS. Thank you, Mr. Pantos.

[The prepared statement and attachment follow:]

**STATEMENT OF
SELF-INSURANCE INSTITUTE OF AMERICA, INC.
hearing on
THE EMPLOYER MANDATE AND HEALTH REFORM
before the
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
February 3, 1994**

Mr. Chairman, members of the Subcommittee, I am George Pantos, Washington Counsel for the Self-Insurance Institute of America, Inc. (SIIA). On behalf of SIIA, I am pleased to offer comments on the employer mandate and health reform.

The Self-Insurance Institute of America, Inc. (SIIA), is a national trade association serving the self-insurance industry. SIIA has over 1500 members -- representing over 60 million American workers -- and includes employers, third-party administrators, managing general underwriters, insurance companies, reinsurers and others dedicated to the advancement of self-insurance. SIIA is the only U.S. association that represents firms, individuals and organizations which participate in the broad spectrum of self-insurance, including the self-insurance of health benefits.

The Clinton Administration's Health Security Act imposes at least three new burdens on businesses:

- All employers will be required to pay 80% of each employee's health insurance costs, referred to as the employer mandate.
- Employers of fewer than 5,000 employees will be forced to obtain their health insurance through large regional health insurance purchasing groups called "Health Alliances."
- Employers of fewer than 5,000 employees will be compelled to abandon their present health plans, including their self-funded plans.

SIIA is opposed to the employer mandate because it will cause job loss, it is unnecessary to resolve current health care problems and it will eliminate many beneficial aspects of the present American health care system. Moreover, SIIA does not believe that the employer mandate will reduce a root cause of the nation's health problems -- skyrocketing health care costs.

Employer Mandate Will Cause Job Loss

Forcing employers to provide and pay for their employees' health benefits will have a potential adverse impact on the jobs of many American workers. Under the Administration plan, for each worker, employers will pay 80% of the cost of the average priced plan in the regional health alliance, depending on the employee's family status. This contribution level will result in a higher payment than what businesses currently pay, and will include part-time and seasonal workers employed for as little as 10 hours a week.

Increased health plan costs mean higher labor costs, which inevitably reduce the number of job opportunities. Moreover, higher labor costs will be shifted onto employees by the reduction of other benefits, hours or wages, or onto customers in the form of higher prices.

While the Administration estimates job loss at 600,000 nationally, many existing studies indicate the figure will be higher. A study by the Employee Benefit Research Institute estimates that as many as 1.2 million workers would lose their jobs due to an employer health insurance mandate.

Another survey conducted last year by CONSAD, an independent health policy research firm, found that from 7.5 million to 18 million American jobs would be put "at risk" of either being eliminated or cut back in terms of reduced hours, benefits, or wages.

The placing at risk of countless job opportunities would fall most heavily on those needing the most help. CONRAD found that an employer mandate would disproportionately harm young, low-income, minority, and under-educated workers.

Additionally, many employers who now provide health benefit coverage will experience a significant increase in their health care costs under an employer mandate. This is especially true of employers who typically have healthier, younger work forces and who have lower health plan costs because they pose lower risks than older, less healthy work forces. Those in retailing, professional services, light manufacturing and the high technology field have average annual medical benefit costs that are lower than for manufacturing companies.¹

Even many small employers who receive government subsidies have stated they will be forced to raise prices, fire part-time workers, and lay off higher-wage workers to be replaced by lower-paid employees.

An Employer Mandate Is Not Necessary

At present, eighty-eight percent (88%) of Americans have health coverage, and ninety-two percent (92%) of those covered receive health benefits through their employer. Sixty-seven percent (67%) of employees covered by employer-sponsored group health plans receive coverage through self-funded plans, according to a 1991 survey by A. Foster Higgins. In other words, nine out of ten covered Americans do not need an employer mandate, including nearly seven out of ten covered Americans who currently receive health benefits from employer-sponsored self-funded group health plans. Stated another way, the vast majority of employers currently voluntarily provide health benefit coverage to their employees and do not need an employer mandate to do so.

As for employers who do not currently provide health plans, surveys indicate most cannot afford to do so. A recent National Federation of Independent Business (NFIB) survey found that 65% of employers who did not provide health insurance cited the high cost of insurance as their sole reason for not doing so. In another NFIB survey, employers were asked what they would do if required to contribute \$150 a month per employee for health insurance. The survey found that 26% would close their businesses, and nearly 24% said they would let all employees go and continue operating without them as a self-employed business. NFIB's small business members include employers whose average size is less than 10 employees.

Thus, government action forcing small firms to buy health coverage for their employees will not make benefit plans more available and affordable -- it will cost many of these employees their jobs.

Another cost of the employer mandate: it will likely lead to even more government action in the form of price controls or subsidies to small employers. In sum, while the employer mandate may appear appealing to some, the negative consequences of the mandate raise serious policy questions which must be addressed before any final legislative action is taken.

Changes In The Present Health System Are Underway

Evidence available in the form of polls and surveys indicates that -- even without health reform legislation -- positive changes are already underway in the nation's health care system. The consumer price index for medical goods and services has been dropping steadily according to the Bureau of Labor Statistics. In addition, the average hospital occupancy rate has dropped significantly and cost-cutting managed care programs have become the norm rather than the exception.

¹ Average medical insurance costs were 8.4% of payroll in 1990 for manufacturing companies, compared to 6.7 percent of payroll for non-manufacturing companies. (EBRI Data-book of Employee Benefits, Second Edition, page 31).

Moreover, under the present system, more health care plans are being funded directly by employers than by insurance companies. Two out of every three American employees covered by employer-sponsored group health plans receive their benefits from self-funded health plans. (A. Foster Higgins, Health Care Benefits Survey, 1991). The phenomenal rise of self-insurance, also referred to as the self-funding of health benefits, is directly related to recognition by employers of all sizes that self-funding can cut costs without reducing benefits or sacrificing quality.

This dramatic increase underscores the cost-saving innovation in health care and its financing due in great part to employer involvement in the health system. This trend emphasizes that there is no basis in fact for dismantling an entire employment based infrastructure built up over the years and replacing it with a network of unproven health alliances based on an impersonal bureaucracy administered by state governments.

Moreover, there is no basis for the arbitrary 5,000-employee threshold set by the Clinton plan which would force thousands of employers who today are involved in the health care of their employees, to abandon their plans and submit to a system of government run alliances.

If self-funded employers are forced into health alliances and are not allowed to continue their own health plans, they no longer will share the risk of providing benefits to their employees. Clearly, without a direct dollars and cents incentive to do so, many employers will likely spend less on such activities as worksite wellness programs, especially during more difficult economic times.

Employees Are Satisfied With Their Current Health Benefits

Like most Americans, SIIA members are very concerned about the U.S. health care system and support changes that would improve the system. At the same time, SIIA concurs with recent surveys which suggest that most American workers are satisfied with their health benefits and would like to remain covered by employer-sponsored plans.

Polls taken over the past two years show that the majority of covered Americans are satisfied with their own health plans. A recent Associated Press poll found that 54 percent of Americans believe they would be better off under the current health system, with only 39 percent saying they personally would have better coverage under the Clinton plan. Reflecting these national figures, a recent SIIA survey found that beneficiaries under self-insured plans are overwhelmingly satisfied with their current benefit programs and their coverage under those plans.

Conclusion

Current efforts to restructure our health care system -- one eighth of the U.S. economy-- are largely driven by polls which suggest wide public support for health reform. However, other polls suggest a lack of broad-based support for President Clinton's unproven health care experiment. While President Clinton is correct to identify health care problems such as soaring costs and lack of access, his reform plan goes in the wrong direction. SIIA believes that insurance reforms, small employer reform, greater competition, enhanced choices, financial incentives to individuals and employers, and other market approaches are needed to resolve current health problems. The President's call for more government involvement in the health marketplace is the wrong prescription for the problems of cost and access, and the employer mandate will only serve to exacerbate rather than to resolve current health system problems.

Respectfully Submitted,

SELF-INSURANCE INSTITUTE OF AMERICA, INC.

George Pantos
Washington Counsel

James A. Kinder
Executive Vice President

Mr. JACOBS. Mr. Ford.

Mr. FORD. Mr. Richey, are you in opposition to the employer mandates, the mandates that we have been talking about today?

Mr. RICHEY. No, sir, we believe everybody should be covered somehow, and there should be some kind of mandated coverage.

Mr. FORD. Businesses with 5,000 employees or fewer would be mandated to contribute to coverage through the regional alliances. Are you suggesting that like smaller companies, your own company with 3,200 employees should be exempt from participation? Should we lower that number from 5,000 to 2,500 to address the medium companies?

Mr. RICHEY. We believe it should be lowered. The number that I have heard, Mr. Congressman, has been around 500. I think that threshold would make a nice number for people to have the option above 500 employees whether they would like to join.

Mr. FORD. Is there anything significant about the number 5,000? I don't know, I mean, you certainly made a good case. You are self-insured, is that right?

Mr. RICHEY. That is right.

Mr. FORD. You make a good case, and I don't know why the threshold is set at 5,000 for larger businesses. I don't have any idea. Can you—who is suggesting the 5—let's drop the threshold to 500?

Mr. RICHEY. I believe I heard in the news that it has been talked about by the administration. The 5,000, of course, is the number in the President's Health Security Act; that is what he has proposed. I have heard there has been some talk now that maybe the 5,000 number could be lowered. In other words, a threshold could be lowered so that it would be optional for companies in the low—

Mr. FORD. And that would solve a problem like yours with a medium-sized, you know, business in America today that would not have opposition to the mandates, but would support, I guess, the administration's package if we lowered the threshold maybe to something lower than the 5,000, maybe 1,000 or 500?

Mr. RICHEY. That would take, as far as my company is concerned, that would take the major objection away.

Mr. FORD. Thank you, Mr. Chairman.

Mr. JACOBS. Mr. Kleczka.

Mr. KLECZKA. Mr. Chairman.

Very briefly, Mr. Pantos, what is a self-insurance industry? Do you represent insurers who provide self-insurance to corporations?

Mr. PANTOS. The self-insurance industry is made up of a diverse number of elements. It includes employers who provide self-insurance to their employees of all sizes, small, medium and large. It includes stop-loss insurance carriers which cover the catastrophic aspect of self-insurance above a certain threshold. It includes consultants, third-party administrators and a number of others who provide—

Mr. KLECZKA. A lot of whom wouldn't be necessary if we pass the Clinton bill, I assume?

Mr. PANTOS. Beg your pardon, sir?

Mr. KLECZKA. A lot of these folks wouldn't be necessary if we pass the Clinton bill?

Mr. PANTOS. Well, if the Clinton proposal as written is passed, it is the end of self-insurance as we know it today.

Mr. KLECZKA. Not necessarily, not for the corporate alliances.

Mr. PANTOS. Well, the corporate alliances, 99 percent of the—

Mr. KLECZKA. It might be the end of your industry or your institute, but not for large corporate alliances.

Mr. PANTOS. What about the others? There are many employers who are not over 5,000 who are self-insured, and those would be eliminated. And that is one of the reasons that we don't accept this proposal.

Mr. KLECZKA. Well, there are other reasons, I am sure.

Mr. Becker, you indicated that we shouldn't lock ourselves in with a benefit package that is ongoing and is unable to be changed in future years. For your corporation, would your benefit package for your employees be better or about average to what the President has proposed in his bill as far as the basic benefit package?

Mr. BECKER. It would be reasonably similar to what the President has proposed, yes.

Mr. KLECZKA. About the same, OK. So then are you still objecting to putting that into law, that every policy shall offer this basic core of benefits?

Mr. BECKER. Our Coalition feels there is probably some level of basic benefit, but we haven't decided on what that level is at this point.

Mr. KLECZKA. There have got to be some ground rules so we can compare apples and apples and oranges and oranges.

Mr. BECKER. Exactly.

Mr. KLECZKA. Thank you very much, Mr. Chairman.

Mr. JACOBS. Mr. Payne.

Mr. PAYNE. Thank you very much, Mr. Chairman.

Mr. Williams, I want to thank you for those remarks concerning rural health. My own district has 17 rural counties. Eleven have been deemed to be medically underserved at the present time; and truly one of the things that we must address as we address health care reform is the needs that do exist for access to primary health care in rural areas. I appreciate that comment.

Mr. Richey, you mentioned—well, let me first ask a question. What is the cost of health care as a percent of the payroll in your company today?

Mr. RICHEY. It is 15 percent of payroll.

Mr. PAYNE. Fifteen percent, and as I understand the President's proposal, or the President's bill, you would be able under his bill to be insured for 8.9 percent of payroll; is that correct?

Mr. RICHEY. The number I have heard was 7.9, but that would be less of an insurance coverage. Our employees pay no premiums; we have our own doctors, our own dentists. Dr. Gibbs is here with me today as our medical director. We like having our own clinic so that the doctors and the dentists and the pharmacy are all company employees.

Mr. PAYNE. So you are not persuaded by the fact that you could have some kind of insurance coverage for your company for substantially less than you are currently paying? You would prefer to do what you are doing now and continue to maintain that within the company and maintain that kind of control?

Mr. RICHEY. Yes, sir, we prefer to be able to differentiate our company from other companies. We think it helps us retain good employees. We have an average 18-year tenure; it helps us retain employees. It helps us to attract the kind of employees that other companies would like to have.

Mr. PAYNE. So you might see that then as an investment in personnel that you would get some kind of return on in the longer term?

Mr. RICHEY. That is correct.

Mr. PAYNE. Thank you.

I had one other question. Mr. Pantos, you mentioned that there was dramatic increase in self-insurance. Why is that?

Mr. PANTOS. The principal reason is, employers have found it increasingly attractive to shift to paying the benefits out of their own pocket, like they pay other expenses, instead of carrying those benefits through insurers. Because the costs are less in many instances, they enjoy the cash float on the money, which they keep in their own treasury until they have to pay the benefits, rather than paying insurance carriers. And those costs that are paid to insurance carriers include not only the costs of benefits but the profits of the insurance companies and reserves. So—the cost of administration is significantly lower through third-party administrators and insurance carriers who do only administration.

Because of these and other cost innovations, the ability to be close to the employee and to be able to deal directly with the employee, the employer-employee relationship, there has been a phenomenal increase in the number of employers who have found self-insurance to be a more attractive mechanism than insured coverage.

Mr. PAYNE. And many of those, I would assume, might have managed care programs as well?

Mr. PANTOS. As a matter of fact, managed care programs were initiated back in the 1980s, started in many cases with small employers who were self-insured, who found techniques and devices in which they could bring their own costs under control because this went to their own bottom line.

Mr. PAYNE. Thank you very much.

Mr. JACOBS. OK.

Mr. Santorum.

Mr. SANTORUM. No questions.

Mr. JACOBS. No questions.

We thank the panel for your contribution.

Mr. JACOBS. Will the next panel please come forward? Max Moore, Oklahoma Steel & Wire Co.; Carolyn Kelley, the American Payroll Association; Robert Williamson, American Society for Payroll Management; and Gary Kushner, Society of Human Resource Management.

Mr. Moore? Is Mr. Moore present? Well, we will see if Mr. Moore comes in.

Ms. Kelley, you are next in line. Kelley and O'Toole, that sounds somehow right.

**STATEMENT OF CAROLYN KELLEY, DIRECTOR OF
GOVERNMENT AND PUBLIC AFFAIRS, AMERICAN PAYROLL
ASSOCIATION**

Ms. KELLEY. OK. Thank you, Mr. Chairman.

The American Payroll Association is a nonprofit professional association representing 10,000 executives engaged in payroll management. We represent the operations professionals who will be charged with calculating and deducting the proposed employee health care premium from employees' paychecks, calculating the employer's contribution, remitting the moneys, and reporting information for compliance programs.

Our testimony today focuses specifically on the cost to employers of these kinds of operational and administrative processes, and suggests that businesses and Congress can work together to control these costs.

The administrative centerpieces of the President's proposal for health care reform are the various withholding, information reporting, depositing and recordkeeping requirements placed on employers. Employers will have to build large new data banks of information on employees, their dependents and benefit plans in order to comply with these administrative requirements. This is an extremely costly endeavor for American businesses and, with respect, one which has traditionally been poorly understood by Congress.

In testimony before this committee on November 18, APA urged Congress to prevent runaway costs to employers by ensuring that certain fundamental goals are met during the creation of a new health care system. Very briefly, these goals again are:

One, that Congress work with the private sector during this process;

Two, that Congress provide for standardization of systems features; and

Three, that Congress understands what constitutes adequate time for businesses to implement these kinds of requirements. And we have included some information from the November 18 testimony for you.

We are alarmed by the large bureaucracy contemplated in the Health Security Act. We are very concerned that employers will be caught in a myriad of different withholding, reporting and depositing requirements, promulgated by various entities on different formats, as in the current wage reporting system.

Let us assume that these costs are insignificant, according to a recent study by the Tax Foundation, American business spent \$123.4 billion in 1993 to comply with Federal tax laws. This amount of money could be used to train and employ a lot of people and provide a good deal of health care. With a view to minimizing unnecessary costs for employers, we have submitted written testimony to the committee outlining our general support for the Stark alternative, which proposes using payroll systems and existing IRS collection mechanisms for the withholding, reporting and depositing of the employee health care premium.

At the same time, and again with respect, we caution that Mr. Stark's testimony that this approach, "Doesn't require much more than an additional line on an existing form," is a vast understatement.

ment of the operation issues and costs involved for both the IRS and employers.

To illustrate the above discussions, APA would like to draw the committee's attention to a current situation, and those are the problems and costs for employers associated with implementing section 13581 of the Omnibus Budget Reconciliation Act of 1993, directing the Secretary of HHS to establish the Medicare and Medicaid coverage data bank.

Although the provision was enacted to address problems associated with enforcement of the MSP provisions, the term "electing individual" forces employers to build and maintain whole new banks of data on all employees.

Mr. JACOBS. Ms. Kelley, we have an accounting problem, too. Your time has expired, but maybe you can develop the rest of the ideas during the questioning, perhaps.

Ms. KELLEY. OK.

Mr. JACOBS. Thank you.

[The prepared statement follows:]



American Payroll Association

New York Education Division

Testimony of the American Payroll Association
Before the House Ways and Means Committee
February 3, 1994

Presented by:
Carolyn Kelley
Director, Government and Public Affairs

The American Payroll Association is a non-profit professional association representing 10,000 executives engaged in payroll management, i.e., wage and employment tax withholding, reporting and depositing and all other automated and manual processes involved in paying employees. As such, we represent the operations professionals who would be charged with calculating and deducting the Employee Health Care Premium from employees' paychecks, calculating the employer's contribution, remitting the monies and reporting information for compliance programs to the proper parties. We are pleased to provide comments on the administrative, collection and compliance issues arising from health care reform.

The administrative centerpieces of the current proposals for health care reform are the various withholding, information reporting, depositing, and record keeping requirements placed on employers. Employers will have to build large new data banks of information on employees, their dependents and benefit plans in order to comply with these administrative requirements. This is an extremely costly endeavor for American businesses which has been traditionally poorly understood by Congress.

In testimony before this Committee on November 18, APA urged Congress to prevent runaway costs to employers by ensuring that the following goals are met:

1. Legislators and appropriate implementing agencies must work with the private sector during the design and implementation of any new health care system.
2. The system must be designed and the legislative language specifically provide for the standardization of terms, definitions, (especially how to calculate health plan contributions or taxes on excess health plan benefits that are based on a "percent of payroll," an undefined term), reporting formats, transmission

methods, required data elements, record keeping requirements, audit method and penalty authority, amounts, and method of assessment. Without this standardization, costs to employers will escalate geometrically.

3. Legislators must understand what constitutes adequate time for implementing these kinds of requirements, both for the implementing agencies and for American businesses. This is also traditionally poorly understood by Congress - at great cost to employers, who are placed under penalty exposure due to inadequate and/or unclear guidance and unrealistic effective dates imposed by legislation. This causes employers to hastily assemble systems which then have to be reworked and forces compliant taxpayers into costly situations of controversy with enforcement agencies. We have repeated the section on implementation processes from our November 18 testimony below:

*** *** ***

There are a number of steps involved for implementing any legislation of this kind, and they cannot be compressed. They are:

- Creation of guidance by agencies for employers on how to accomplish each process required of them.
- Educating employers about their obligations.
- Creation of new data bases/systems needed for compliance by both agencies and employers.
- Software design and testing for both agencies and employers.
- Testing these new systems for accuracy by both agencies and employers before employers become liable for penalties.
- Training both private sector and agency employees.

Again it is important to note that these processes are accomplished in a linear fashion. They cannot be accomplished concurrently. Congress must allow for realistic effective dates, recognizing that it takes a finite amount of time for agencies to produce guidance. Then, it takes another amount of time to educate employers and state and local authorities, who may or may not have to make system changes. It then takes another amount of time for employers to create data bases, design and test new software and train employees in new methods of compliance. Therefore, government must work with the private sector to design realistic implementation schedules. Again, at least in tax matters, the public sector does not have a good track record in this regard in recent years. We urge Congress to set and include realistic effective dates in the legislative language for health care reform.

*** *** ***

In addition, we are alarmed by the creation of the huge bureaucracy contemplated by the Health Security Act, which is divided into Regional Alliances and a National Health Board. We are concerned that employers will be caught in a myriad of different withholding, reporting and depositing requirements promulgated by various entities on different formats, as in the current wage reporting system. According to a recent study by the Tax Foundation, a nonpartisan Washington research group, which was reported last Sunday in The New York Times, American business spent \$123.4 billion in 1993 to comply with Federal tax laws. Small businesses, with assets of less than \$1 million, spent an average of \$390 for Federal tax compliance for each \$100 of Federal taxes they paid. The majority of these compliance costs relate to payroll taxes, information reporting and related record keeping requirements. The Health Security Act must attempt to minimize any further escalation of this already overwhelming business burden. We also direct the Committee to examine the current annual wage reporting system, which has been targeted by the National Performance Review as an example of the hefty and unnecessary costs imposed by such a bureaucracy.

With a view to minimizing unnecessary cost for employers, we have submitted written testimony to Chairman Rostenkowski outlining our general support for the "Stark Alternative" which proposes using payroll systems and existing IRS collection mechanisms for the withholding, reporting and depositing of the Employee Health Care Premium. At the same time, we caution that Mr. Stark's testimony that this approach "doesn't require much more than an additional line on an existing form" is a vast understatement of the operations issues involved for both the IRS and employers.

In illustration of the above discussions, APA would like to draw the Committee's attention to the current problems and costs for employers associated with implementing section 13581 of the Omnibus Budget Reconciliation Act of 1993, directing the Secretary of Health and Human Services (HHS) to establish the Medicare and Medicaid Coverage Data Bank.

The provision requires employers to provide the following detailed information on the health insurance coverage they provide to electing individuals:

1. The name and Social Security Number (SSN) of the electing individual;
2. The type of group coverage (i.e. single or family) elected;
3. The name, address and identifying number of the plan;
4. The name and SSN of each other individual covered under the plan (i.e. spouse and dependents);

5. The period covered by the election; and
6. The name, address and EIN of the employer.

Although the provision was enacted to address problems associated with enforcement of the "Medicare as Secondary Payer" (MSP) provisions, the term "electing individual" forces employers to build and maintain whole new data bases on all employees and their dependents, even though (according to the GAO, industry experts and a survey by the APA), only about 1% of employees are affected by the MSP provisions.

Even though employers would have had to begin collecting data on employees last fall to ensure compliance, HCFA has announced that the legislation did not provide enough time for a regulatory process. HCFA can thus only produce "preliminary guidance" (in the form of an announcement) by March of this year. This leaves employers to begin building systems and data banks by guesswork. It is all but assured that costly systems modifications will then be needed as guidance is produced.

The APA estimates that the cost of compliance for a medium-sized employer will range between \$50,000 and \$100,000 per company in the first year, with substantial annual costs thereafter. For larger employers and payroll service bureaus the costs are estimated to range between \$3 million and \$5 million.

Ironically, most of these costs will go for naught. In a letter to the Office of Management and Budget, the Assistant Secretary for Management and Budget of HHS stated that the provision "will probably not greatly enhance Medicare secondary payer or Medicaid third party liability collections." (Letter from Kenneth S. Apfel, Assistant Secretary for Management and Budget, U.S. Department of Health and Human Services, to Nancy-Ann Min, Associate Director for Health, U.S. Office of Management and Budget, dated September 30, 1993.) The letter goes on to state that HCFA must spend a minimum of \$17 million in FY 1994 to design and implement the data bank, as well as \$25-30 million annually to operate the system. These funds were not authorized or appropriated by Congress for these purposes. Thus, even if the data are collected by employers beginning in 1994, it will be useless to HCFA until its data bank is up and running and probably, for the purpose of the stated program, even after the data bank is set up.

So, we now have a situation where employers are obligated, under a poorly designed law, in the absence of adequate guidance for voluntary compliance, and under penalty exposure to a maximum of \$250,000 per employer, to build and maintain a data base of information and to report information (at great cost to employers) to an agency which has not been funded to process the information and which, if it were, would not be able to use the information to solve the problem which the legislation intended to solve.

Additionally, at least with respect to 1994 reporting, this provision has not been dovetailed with the National Health Board data collection clearinghouse called for in the Health Security Act. The conclusion we draw is that in the near future we will have to redesign systems once again to provide for health care reform.

We remind the Committee that these funds could instead be spent to employ workers and produce goods and services and that these kinds of scenarios are completely avoidable, as stated in our discussions above. We urge Congress to take the steps necessary to avoid these results as it moves forward with health care reform legislation.

Thank you.

Mr. JACOBS. Mr. Williamson.

**STATEMENT OF ROBERT D. WILLIAMSON, PRESIDENT,
AMERICAN SOCIETY FOR PAYROLL MANAGEMENT**

Mr. WILLIAMSON. Thank you, Mr. Chairman, for this opportunity to appear before the committee on behalf of the members of the American Society for Payroll Management. The people I represent are payroll employment tax managers at large multi-State and global enterprises. We have submitted already our December 1993 membership survey on the impact of H.R. 3600, so today I am just going to comment briefly on the employer mandate.

There are really two issues here. The first is the financial burden which has been developed already this afternoon; but for large employers, the coverage requirement per se does not necessarily make or break the program, because these employers have the required financial and technical resources, and have been providing their own health care plans.

These employers who have gone the extra mile for their employees are proud of their plans. They deserve credit for having set the global standard against which health care coverage is measured. These same employers have instituted health care cost-containment programs which have begun to show up in the figures. Our colleagues in the Society for Human Resource Management deserve credit for controlling costs and we thank them for having demonstrated that this can be accomplished in the private sector.

What troubles many large employers is how their existing plans would be transformed into the proposed system. The act would require most large employers to abandon their companywide health care programs for regional alliances as an opt-out for employers with 5,000-plus employees, but this is a narrow exception because only about 1,900 of the total 6 million U.S. employers have such a large payroll.

According to our December survey, employers who qualify to opt out would pay an assessment and run their own alliances. That large companies would pay extra to stay out of the proposed program speaks for itself. Everyone else would enter regional alliances, thereby fragmenting companywide programs. The provider who has employees in all States would deal with more than 50 regional alliances, because some States will divide themselves into a number of regional alliances.

Variations among State Tax Code definitions of taxable income add more complexity. The administrative difficulty that these factors cause is illustrated by capping employer and employee contributions to percents of payroll. Computing the amount of the employer's contribution of 7.9 percent would be an administrative nightmare, owing to the various income definitions from State to State. But it could be accomplished, albeit at tremendous effort and expense.

Capping the employee's premium contribution at 3.9 percent of his or her income is an administrative impossibility, because all the employer knows is the employee's annual salary, not the amount of the employee's total income. In short, there is a lot of burden here and some of the provisions simply will not work.

This very brief overview shows the administrative consequences of the employer mandate.

Mr. JACOBS. Mr. Williams, I am sorry, time passes quickly.

Mr. WILLIAMSON. This ends my statement, thank you.

Mr. JACOBS. OK.

[The prepared statement follows:]

AMERICAN SOCIETY FOR PAYROLL MANAGEMENT
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Statement of
Robert D. Williamson, President
American Society for Payroll Management
before the
House Committee on Ways and Means
Hearing on H.R. 3600, Health Security Act
February 3, 1994

Mr. Chairman:

Thank you for this opportunity to appear before the Committee on behalf of the members of the American Society for Payroll Management. The people I represent are payroll and employment tax managers at large, multi-state and global enterprises. We have submitted our December 1993 membership survey on the impact of H.R. 3600 on their operations. Today I will comment on the employer mandate.

A critical question is whether the employer mandate as provided in the Act is appropriate. There are really two issues here. The first is the financial burden for some companies. It will fall heavy on small employers. For large employers, such as those we represent in ASPM, the coverage requirement *per se* does not make or break the program because these employers have the required financial and technical resources and have been providing their own health care plans. These employers, who have gone the extra the extra mile for their employees, are proud of their plans. They deserve credit for having set the global standard against which health care coverage is measured. These same employers have instituted health care cost containment programs which have begun to shown up in the figures. Our colleagues in the Society for Human Resource Management deserve the credit for controlling costs and we thank them for having demonstrated that this can be accomplished by the private sector.

What troubles employers who provide health care is how their plans would be transformed into the proposed system and -- equally as important -- how they would administer them under the proposed program. So while the additional cost may be the most serious problem for small employers, larger employers may be more concerned about plan administration difficulties, losing control of their programs, and the prospects of quality and service declines from their present coverages.

The Act would require most large employers to abandon their company-wide health care programs for regional alliance offerings from which employees would choose their coverages. Employers with 5,000+ employees may opt out if they pay an extra assessment of 1% of their payroll. This is a narrow exception because only about 1,900 of the total of 6-million U.S. employers have such a large payroll. According to our society's December 1993 membership survey,

employers who qualify to opt out would pay the assessment and run their own alliances. That large companies would pay extra to stay out of the proposed program speaks for itself.

All the other employers enter regional alliances, thereby fragmenting the company-wide programs of multi-state employers. When the employees enroll in their regional alliances or move from one alliance to another, they come under the alliance rules. The employer who has employees in all states would deal with more than 50 regional alliances because some states will divide themselves into a number of regional alliances. Variations among state tax code definitions of taxable income add more complexity. The administrative difficulty that these factors cause is illustrated by capping employer and employee contributions to the percents of payroll as specified in the Act. Computing the amount of the employer's contribution cap of 7.9% of payroll by state would be an administrative nightmare owing to the various income definitions from state to state, but it could be accomplished albeit at tremendous effort and expense. Capping the employee's premium contribution at 3.9% of his or her income is an administrative impossibility because all the employer knows is the employee's annual salary, not the amount of the employee's total income. In short, there's a lot of burden here and some of the provisions simply won't work.

This very brief overview shows that the administrative consequences of the employer mandate are much more than mere inconveniences. The provisions related to employers seem to be administratively impractical. Fine-tuning won't help because the administrative problems stem from the Act's fundamental premise that health care is provided through regional alliances that write their own rules and set their own requirements. We may note that this approach is contrary to another program that enjoys Administration support, the wage reporting simplification project. This has been undertaken by the federal government, the states and the employer community to develop unified wage and tax reporting systems and definitions of wages that would be common among all taxing authorities. The annual savings potential is estimated to be \$13-billion per year in 1993 dollars. The Act could wipe these savings out.

How much more burden is it fair to ask employers to bear? If doing the payroll were just paying employees, the job would be easy. But it's complex because a 50-state employer's payroll tasks now include: being tax collector for some 2,700 authorities, making nonstatutory payroll deductions for employees (often for health care), making statutory deductions such as garnishments and withholdings under child support orders, reporting new hires to child support authorities and even doing the publicity for the advanced payment feature of the earned income tax credit. Add to these tasks another in 1995, reporting to the medicare information data bank. We hope that the Committee agrees that this list of administrative tasks is already long enough. We urge that the both consequences of the employer mandate provided in H.R. 3600 will be considered during the deliberations on the Act, the administrative burden as well as the financial burden.

Mr. JACOBS. Mr. Kushner.

STATEMENT OF GARY KUSHNER, MEMBER, BOARD OF DIRECTORS, SOCIETY FOR HUMAN RESOURCE MANAGEMENT, AND PRESIDENT, KUSHNER AND CO., INC., KALAMAZOO, MICH.

Mr. KUSHNER. Good afternoon, Mr. Chairman. My name is Gary Kushner and I am president of Kushner and Co. My company provides consulting services and administration for a wide range of employee benefit programs. I am testifying today on behalf of the Society for Human Resource Management. SHRM is the leading voice of the human resource profession, representing the interests of more than 56,000 professional and student members from around the world.

With one-seventh of the economy and millions of jobs at stake, we cannot afford to get health care reform wrong. We cannot be guilty of malpractice. As the professionals on the front line, helping to hold down costs while preserving benefits, human resource managers would like to join in the debate to help us get it right.

First off, there is no single health care reform plan that will satisfy everybody, except perhaps one with unlimited or near unlimited benefits that is paid for by somebody else. But unfortunately, Mr. Chairman, that is exactly the way that we have approached health care.

We must change the way we think about health care. That is the only prescription for success.

SHRM believes that both employers and employees must approach health care as educated consumers. Unfortunately, we all consume health care but are terrible consumers of it, knowing neither cost nor quality. SHRM's position on health care is based on three general principles.

First, every citizen should have access to a basic core of health care services. This coverage may be achieved in different ways and at different levels, but any approach to health care reform must offer affordable access to care for all Americans.

To achieve this objective, health care reform should be based on a model which has built-in incentives to balance both quality and cost efficiencies. As part of efforts to control rising costs, both payers and patients must be informed consumers of health care.

Last, SHRM believes that the solution to the problem of the uninsured depends on the careful coordination and planning of all concerned parties. We endorse the continuation of an employer-based system. The problem of the uninsured, however, is a societal one, and not a problem to be resolved solely by employers and other private payers.

Mr. Chairman, central to the Hippocratic Oath, the pledge made by physicians and health care workers, is the principle "Do no harm." I suggest that that would be a good standard for us all as we look at reforming health care.

There are no guarantees in this business, but there is a surprising level of consensus on certain issues. Let us do no harm by moving ahead with what we know will work, like portability and community rating. We must give workers protection when they switch jobs. We should, though, through carefully targeted incentives,

allow and even encourage those workers' employers to band together and increase their purchasing clout in competitive purchasing pools.

President Clinton has taken a step in the right direction by including malpractice reform in his bill. With professional liability premiums rising at over 15 percent a year and the cost of defensive medicine in runaway mode, we must have larger steps taken such as allowing practice protocols to be used as an affirmative defense and placing caps on punitive damages.

Likewise, there is consensus that we should emphasize preventive and primary care. That is one of the strengths behind a managed competition approach to health care. Costs of visiting a doctor for checkups and physicals are kept low. There is some copay requirement, but the basic philosophy is encouraging the ounce of prevention, so that the pound of cure may not become necessary. Thank you, Mr. Chairman.

Mr. JACOBS. Thank you.

[The prepared statement follows:]

**STATEMENT OF GARY KUSHNER
ON BEHALF OF THE
SOCIETY FOR HUMAN RESOURCE MANAGEMENT**

Good afternoon, Mr. Chairman. My name is Gary Kushner, and I am President of Kushner & Company, Inc., a firm providing consulting services and administration for a wide range of employee benefit programs.

I am testifying today on behalf of the Society for Human Resource Management. The Society for Human Resource Management (SHRM) is the leading voice of the human resource profession, representing the interests of more than 56,000 professional and student members from around the world. SHRM provides its membership with ongoing government and media representation, education and information services, conferences and seminars, and publications that equip human resource professionals to become leaders and decision makers within their organizations. The Society is a founding member and Secretariat of the World Federation of Personnel Management Associations (WFPMA) which links human resource associations in 55 nations.

I am pleased to have this opportunity to come before the Ways & Means Committee to give testimony on the vital issue of health care reform. Health care is the singular public policy issue of our day. No other issue cuts so closely, or is so intimately connected with the way we live today and the way we will continue to live tomorrow. It has profound implications for both our personal budgets and our national balance sheet.

And that is the message that I gave when I met with President Clinton and Vice President Gore at the White House back in July of last year. That was the substance of my comments two weeks later to the First Lady, Hilary Rodham Clinton, and to Mr. Ira Magaziner, Director of the Health Reform Task Force.

We have come a long way since that point, and this Committee and others in the Congress now have the opportunity to craft a health care reform bill that is good for Americans. But as with so many other things, the opportunity brings responsibility, and I do not envy you as you analyze the issues and make the tough decisions.

Undoubtedly, the issue of health care reform is also one of the most important challenges facing the human resource profession. As both consumers and purchasers of health care, the more than 56,000 members of SHRM are confronted with the difficulty of providing health coverage to their employees while managing the escalating costs to their businesses. Therefore, SHRM is excited about the prospects for reform of our nation's health care system.

However, we are equally concerned about the shape that the reform will take. As your Committee continues to refine the details of the President's "Health Security Act" (H.R. 3600) and to examine alternative health proposals, real world experiences of human resource managers in designing employee health plans will provide invaluable information. Since human resource practitioners will be responsible for implementing and integrating new health care reform requirements with existing benefits plans, SHRM is uniquely suited to provide practical insights on the effects of the proposal.

First of all, SHRM would like to commend President Clinton and the Administration for their efforts to address the critical and complex issue of health care reform. We appreciate the goals of security, simplicity, savings, choice, quality, and responsibility. However, since the devil is often in the details, we would like to offer the following specific comments on the proposal based on the framework of health care principles approved by our Board of Directors in 1992:

I. Employer Mandate

SHRM believes that employers should not be required to pay for a portion of their employees health premiums -- particularly not an amount as high as 80 percent as proposed by the "Health Security

Act." According to the Employee Benefit Research Institute (EBRI), a mandate that employers cover a high amount of employee health premiums would result in a net loss of 168,000 jobs. Other academics and organizations estimate an even higher number of jobs lost.

This does not count the administrative difficulties the mandate would impose. The American Society for Payroll Management readily attests to the complications already involved in coordinating payroll systems to account for collection of taxes, and making statutory and nonstatutory deductions. These problems would only be made worse in carrying out a new responsibility required by the mandate and other provisions of the health care reform proposal.

For that reason, SHRM believes that the solution to the problem of the uninsured depends on the careful coordination and planning of all concerned parties. We endorse the continuation of an employer-based system. We believe that the problem of the uninsured is a societal problem and not a problem solely to be resolved by employers and other private payers. Accordingly, SHRM opposes pay or play proposals which require an employer to either provide coverage to their employees or contribute a percentage of their payroll to a government insurance fund. SHRM strongly opposes any proposal that imposes a mandate on employers as the sole solution to health care reform.

II. Basic Benefits Package

SHRM believes that the basic core of health care services should emphasize preventive care and commends you for including preventive care in your package. SHRM is concerned, however, that design of the basic benefits package is too generous and does not carefully consider the costs of providing these benefits.

III. Purchasing Pools

SHRM believes that small employers should be encouraged to form risk sharing groups to obtain affordable coverage. The government should provide incentives and/or sponsor public/private vehicles for risk sharing and/or insurance. While SHRM supports the creation of purchasing pools to give small businesses more bargaining power, SHRM believes more than one health alliance should be permitted in a geographic region so that employers have a choice of a purchasing agent. SHRM supports allowing multiple competing health alliances within an area and permitting smaller employers to band together to form a competing health alliance.

In addition, the Health Security Act's requirement for most employers to purchase coverage through the health alliance would negatively affect many mid-size employers who are currently self-insured. As proposed, we believe that the 5000 employee limit is far too high, affecting only a handful of employers, while disenfranchising thousands more.

IV. Corporate Alliances/ERISA

SHRM believes that the Health Security Act would discourage employers from electing to maintain self-insured plans or negotiating directly with a health plan. Only employers with more than 5000 employees who elect to establish a corporate alliance to maintain self-insured plans would qualify for an exemption under the Employee Retirement Income Security Act (ERISA). ERISA would be amended to require corporate alliances to meet new federal guidelines. In addition, the statute would be amended to permit taxes and assessments on corporate alliances.

SHRM strongly opposes this erosion of ERISA preemption. National health care reform should include a uniform set of federal rules and regulations and should apply to those purchasing health care, rather than the wide variations existing from state to state. Rather than being reduced, we believe that preemption under ERISA should be expanded to address all health standards. Health care plans and the laws that apply to them are complex enough. Employers who want to expand regionally or nationally should not be inhibited from doing so by a maze of conflicting state requirements. Further, employers currently self insure to better manage the costs of their plans and meet their employees' needs. Under President Clinton's plan, employers would no longer have this control over the design of their plans.

V. State Authority

Under the Health Security Act, ERISA would be amended to permit any state or part of a state to establish a single payer system of health care. This provision would allow the federal government to waive ERISA requirements and other rules governing corporate alliances, thereby eliminating corporate alliances in states or parts of states.

SHRM opposes health care reform provisions that would give states a "blank check" to disregard federal directives and impose their own version of health care on the employers located within their borders. Specifically, SHRM opposes granting states the authority to establish a single-payer system of health care at the federal/state level. Such a system would eliminate the competitive forces of an employer-based system which can promote quality and reduce costs.

Under President Clinton's plan, it is likely that additional state regulations would affect employers. For instance, states could require plans to provide benefits in excess of any federal standard benefits package. Health alliances could be run by the states, and states could impose taxes on provider services which could be passed on indirectly to employers and employees.

Many SHRM members work for self-insured companies with operations in multiple states and are concerned that under the new system they will have to begin complying with a patchwork of state laws.

VI. Employee Contribution

We strongly believe that incentives should be provided to encourage payers and patients to act as consumers in choosing health care services that are cost-effective. Deductibles, copayments and reasonable contributions by participants should also exist to encourage individuals to make consumer-like decisions about health care. Specifically, employees should be required to make some level of copayment. This would help to prevent the utilization of health care services from rising uncontrollably as coverage expands. Therefore, the level of employee copayments and deductibles should be high enough to discourage unnecessary utilization of health services.

VII. Taxation of Benefits

The Health Security Act would permit employers to continue to deduct the cost of the basic benefits package as a business expense. The cost of additional benefits would be taxable as income to employees after a 10 year grandfather clause. Section 125 or "cafeteria" plans would be amended to exclude employee contributions for health benefits.

SHRM believes the tax structure should encourage payers and patients to act as consumers in choosing health care services that are cost effective. SHRM strongly supports the continuation of Section 125 benefit programs since they encourage employees to plan for their medical expenses.

VIII. Workers' Compensation

Initially, the Health Security Act would require that workers' compensation related health care treatment be provided through the state-certified health plans. These health plans would designate a case manager to handle job-related injuries and illnesses and adopt certain treatment guidelines for handling workers' compensation cases. In addition, a new Commission would be established to study the feasibility of fully integrating the medical part of workers' compensation with the health care system and make recommendations by 1995.

SHRM is in the process of developing a position on the coordination of the workers' compensation and health care systems. However, any reform should not result in cost-shifting to the payers who reimburse the costs of care for job related injuries and illnesses. Changes should not jeopardize the existing incentives for safety nor affect the exclusive remedy. Also, any system should help employers control indemnity costs by encouraging employees' rapid return to work.

IX. Malpractice reform

The Administration's health plan would establish a mandatory, non-binding Alternative Dispute Resolution (ADR) mechanism to settle complaints. Attorneys' fees would be limited to a maximum of 1/3 of an award and states could impose lower limits. It would also establish a pilot program of practice parameters to set guidelines for appropriate care and establish grant programs for state demonstration projects in enterprise liability. It does not, however, set any limits on punitive damages which contribute to the high costs of malpractice.

SHRM believes that reform of the medical malpractice system could contribute significantly to the reduction of health care costs. Any comprehensive health care reform proposal should improve this system to avoid wasted energy and money spent on unnecessary "defensive" medicine and litigation.

X. Insurance Reforms

The Administration's plan would prohibit preexisting exclusions and waiting periods. Plans would not be able to terminate, restrict or limit coverage for any reason, including non-payment of premiums, and a system of community rating would also be established.

SHRM supports insurance reform provisions which address portability, risk sharing, and community ratings, particularly in the small market.

XI. Individual Obligation

According to the Administration's proposal, it is the obligation of every individual to enroll in a health plan. Therefore, anyone who does not meet the established deadline for enrollment is automatically enrolled in a health plan when they seek medical care.

SHRM recognizes that the costs of unpaid health care for the uninsured and the underinsured result in increased health care costs to the private sector. By requiring all individuals to have health coverage, the costs to the insured of treating the uninsured would be reduced. SHRM believes that a strong disincentive should be provided to prevent individuals from postponing enrollment in a health plan.

XII. Health Plans

As we understand the "Health Security Act", every employee would have a choice of at least three health plans each with a point-of-service option.

SHRM believes that the use of managed care programs should be expanded. Managed care allows employers, providers and employees to reduce health care spending together. There are various types of managed care programs, and employers and employees could decide which type is best suited for their specific needs.

Employers of all sizes have been able to provide sound and informed choices for their employees. While the goal of presenting several options to employees is laudable, any health reform proposal should enable employers to meet the information needs of their employees without creating unnecessarily complex administration and communication requirements.

In general, while the low cost-sharing plan should indeed cost employees less than high cost-sharing plan, its pricing and the reporting of qualitative measures must still promote consumer-like behavior.

XIII. Cost/Financing

SHRM believes that health care reforms should be based on a model which has built-in incentives to balance both quality and cost-efficiencies. Any cost-containment proposal should contain measures to eliminate cost-shifting. SHRM is concerned by criticism of the Administration's financing mechanism and will evaluate the financing mechanism of any health reform proposal since inadequate funding will lead to further cost-shifting.

In conclusion, SHRM recognizes that there is no panacea for health care reform. It is a system that requires comprehensive reform and the compromise of all parties involved. Accordingly, we urge you to consider the concerns of human resource experts throughout the next several months as you finalize health reform legislation. I would be happy to answer any questions.

Mr. JACOBS. Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman.

Mr. Williamson, I reread your statement again, thinking I missed something the first time around, but you are, one would say, rather negative about the President's proposal, but nowhere in here do I see any recommendations to solve the health care problem we are facing.

Does the organization not think we have a health care problem in the country, or do you think by just leaving it alone it is going to be better? It is going to go away?

Mr. WILLIAMSON. No, we didn't intend to offer a comprehensive proposal. Our group's—

Mr. KLECZKA. Do you have any ideas on how we could reform the current system?

Mr. WILLIAMSON. Well, our group has not taken a position.

Mr. KLECZKA. That is the hard part; it is easy to be to be critical. It is always nice to be negative, but it is more difficult to be positive.

What does your organization think of the employer mandate?

Mr. WILLIAMSON. The people that are members of our group are large companies. They have voluntarily given health care to their employees as a benefit of working for the company. They don't have any problem with it. They have done this on their own, and they continue to do so.

Mr. KLECZKA. Do you have any other ideas how we could reform the current system to make it more efficient?

Mr. WILLIAMSON. Speaking for myself and not for the members, because we have not addressed this in terms of survey work as an overall position, but I think that I would speak for the members in saying that as much of the existing system as can be left alone should be left alone, and it should be fine-tuned and improved without throwing the baby out with the bath water, so to speak.

Mr. KLECZKA. Thirty-seven million Americans who don't have coverage today will just magically go away?

Mr. WILLIAMSON. No, no, provision has to be made for them, but it doesn't mean that you have to throw out all these other plans, I don't think.

Mr. KLECZKA. Thank you very much.

Mr. JACOBS. Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

Ms. Kelley, you indicated that you liked the chairman of the subcommittee's proposal, Mr. Stark's. Have you looked at H.R. 3704 and the fact that we use the Internal Revenue Code as the mechanism for the individual mandate for health care; the Chafee-Thomas bill?

Ms. KELLEY. No, sir, I have not, and I am not prepared to comment on this at this time, but we would be most happy to take a look at it and provide testimony for the written record.

Mr. THOMAS. Your testimony, albeit to the Stark bill rather than ours, is exactly the conclusion that I came to as I began examining various alternatives. If you begin with the concept of wanting to provide, as everyone says, universal coverage and not universal access, you really need to go to an individual mandate.

We had testimony, as you may or may not know, from the administration that the provisions in the President's bill regarding the Department of Labor, which would in essence duplicate what we have in the Department of Treasury and the IRS for the collection and dissemination of the employer mandate payroll portion, would cost between \$10 and \$20 billion to set up. And frankly, if they are willing to talk about that much as an opening, imagine the addition to the 123.4 billion as you run 2 different systems, some of it in terms of the taxes and some of it now in terms of this new mandate.

So I invite your attention to H.R. 3704, and really any other piece of legislation that attempts to reach universal coverage, but does so through, I think, the only rational structure, and that is the individual mandate.

Mr. KUSHNER, your concern is, I think, the one at the heart of all of this. I agree with you totally that it is the consumer that is going to be the ultimate solution.

Do you believe that the tax cap or the failure to have a tax cap has helped contribute to the fact that the only threshold question that most people ask who have insurance is, does my insurance cover it?

Mr. KUSHNER. I think the fact that most Americans never see a bill from their doctor, from their hospital, from the laboratories—the example I have used before in front of many groups is one that would never occur. But I always ask the group, if I were on a hospital gurney, being wheeled in and in the middle of having a heart attack, and my doctor stopped me in the hall and said, we have two drugs we can give you, it is your choice—now this is something of a fantasy—the one is streptokinase, which has been around for dozens of years, costs \$178 a shot; the other is the first genetically engineered drug, TPA, at about \$2,000 a shot. If I have both of my arms ready, and he says, which one do you want, I think I have a different answer if I have to pay for that myself or if I have insurance.

Mr. THOMAS. Even on the gurney?

Mr. KUSHNER. Even on the gurney. I might ask for both.

Mr. THOMAS. I agree with you, and if we put a tax cap in, if we require healthy and reasonable copays, if we subsidize the bottom end of the structure by meaningful savings in Medicare, and once we save them, we begin buying down on the subsidy end, but we get people to understand that we are all in it together and that a little bit out of your pocket goes a long way to determining what choices you make, is the kind of long-term change that will bring about a reduction in health care that government can't do at any time period.

Mr. KUSHNER. I couldn't agree more. And, as well, if you look at it from the preventive end, it is the individual who will drive prevention and wellness, not a company, not the government.

Mr. THOMAS. But if you make it an incentive structure, it works even better; and I don't have time to talk about Medisave as at least one option for those people who are willing to take into their own hands a meaningful spending of health care dollars, instead of simply saying take insurance and then cover me later. I appreciate your testimony.

Thank you, Mr. Chairman.

Mr. JACOBS. Mr. Brewster is recognized to welcome Mr. Moore to the panel.

Mr. BREWSTER. Thank you, Mr. Chairman. Mr. Chairman, I am pleased to have Max Moore here today, representing Oklahoma Steel & Wire Co. Mr. Moore has a very innovative approach to health care for his 380 employees, has been very effective in saving a considerable amount of money through that, and I am looking forward to hearing his testimony.

Mr. JACOBS. Mr. Moore, you are recognized.

**STATEMENT OF MAX L. MOORE, PRESIDENT, OKLAHOMA
STEEL & WIRE CO., INC., MADILL, OKLA.**

Mr. MOORE. OK. I apologize for being late. The pace earlier apparently has quickened quite a little bit.

Mr. JACOBS. We understand.

Mr. MOORE. Mr. Chairman, my name is Max Moore. I am president of Oklahoma Steel & Wire, and also Iowa Steel & Wire and Southwestern Wire of Madill, and Norman, Okla., and Centerville, Iowa, respectively.

I am here today to acknowledge that we have problems with the health care plan as presented to the Congress from the Clinton administration and is quite a large concern to ourselves.

Approximately 2 years ago, in 1992, we opted into a self-funded insurance plan. This was prompted by 5 years of earlier massive increases in the health care costs in our small companies. These skyrocketing costs were the primary reason for opting into self-funding because of certain amounts of abuse and overcharging by providers, which we were incapable of impacting through our traditional insurance suppliers.

We went to self-funding, dealt with those problems, have been very successful in holding down our costs, while at the same time providing quality care for our 380 employees and their dependents.

The Clinton plan, as proposed, would eliminate all of the savings that we have made, all of the progress that we have made, and put us right back into an indemnity plan, which would be very similar to what we were involved with before, only managed by bureaucrats.

We do support certain things of the Clinton plan as proposed. Those things such as universal coverage, elimination of preexisting conditions, these things are basic elements that need to be improved or changed in the current system. What we do ask is that our right to voluntarily participate in alliances or groups be maintained. This is quite important to us, to maintain our self-insurance, our self-insured status.

Mr. JACOBS. Thank you, Mr. Moore.

[The prepared statement follows:]

**STATEMENT OF MAX L. MOORE
PRESIDENT
OKLAHOMA STEEL & WIRE CO., INC.**

Good morning, Mr. Chairman and Members of the Committee. I am Max Moore, President of the Oklahoma Steel & Wire Company, located in Madill, Oklahoma, the Southwestern Wire Inc, located in Norman, Oklahoma, and the Iowa Steel and Wire Company, located in Centerville, Iowa. These companies are medium-sized manufacturers of agricultural and industrial wire and welded wire fabric, providing jobs for 380 employees. I appreciate the opportunity to share my views on health care reform with you this morning. Mr. Chairman, the Committee and President Clinton are to be commended for addressing this issue in a serious and timely manner. Health care reform is of critical importance to me, both as an employer and as an individual.

I understand the need for reform and I am anxious to participate in and to contribute to the debate. While I agree with many aspects of the President's plan, I also have issues of concern. I will outline three major principles I believe should be included in any health reform legislation, discuss my company's experience in the health insurance market, and then discuss more broadly both my concerns and support for specific provisions of the health reform plan proposed by President Clinton that are relevant to employers.

First, I endorse the goal of universal coverage. I believe a health care reform package should strive toward this goal through a combination of an individual and an employer mandate. Specifically, all individuals in the U.S. should be required to carry health insurance through a private or public plan. In addition, all employers should be required to offer a basic health insurance package to their employees and employees' dependents. However, employers should not be required to pay any portion of the costs, but should be offered incentives to do so. The government should help make the costs of coverage affordable to low-income individuals and to small, low-wage companies.

Second, to achieve universal coverage, I support establishing voluntary purchasing pools (or alliance) arrangements. Regardless of what these entities are called, they should offer insurance coverage to all seekers, but no one should be forced to purchase coverage through a government-sponsored alliance. However, a group of businesses should be permitted to form a voluntary, private alliance. Although we are capable of self-insuring and offering excellent health care coverage to my employees, under the Clinton plan, we would be forced into a regional alliance, losing our ability to apply the expertise we have developed in functions such as controlling costs and promoting healthy lifestyles. Our experience illustrates that we can continue to operate effectively in the insurance market outside a large, regional pool. Moreover, our experience in rural America suggests that alliances as outlined in the Clinton plan must be revised to operate effectively in underserved areas. For example, alliances must be able to cross state lines. State borders are arbitrary divisions in relation to the population base in America and access to health care providers.

Third, health reform should require a basic benefit package, but the Clinton-proposed package is not basic, it is very generous. Let me define my idea of a basic package. It involves two parts: one -- first-dollar coverage (no copayments or deductibles, for example) for preventive and wellness care, and two -- catastrophic coverage that kicks in after meeting a reasonable deductible (up to \$1000 per person). Benefits beyond the basic package should be an option for employers to offer and individuals to obtain.

These three general features address the major problems in the current health care reform delivery and financing system and should be incorporated into any final health reform package enacted by Congress. To put these features into context, I will explain my company's experience in the health care arena.

Until two years ago, we relied on traditional insurance company provided coverage for our employees' and their dependents' health care. During this time period we experienced several cases of severe overcharging and abuse. We found the insurance company had no incentive to control our costs because they made profits from administrative fees as a proportion of our premiums. Our employees had no incentives to control costs because they enjoyed first dollar coverage. The only way we could get control over our costs was by creating a self-funded plan which has allowed us to involve our employees in the quest to control costs. With this approach, we have been very successful. While controlling costs, we have provided access to first class medical care for our employees and their dependents.

In the past several years, we have noted some problems with the health care system even in places as small as Madill, Norman and Centerville. Let me share some of the things we have learned and the things we have done about them in our self-funded and administrated plan:

1. There is a lack of a causal relationship between medical services received and the cost of those services. Our employees were buffered from the actual costs of their health insurance because they personally didn't see or feel the cost. When there is little or no connection between the price of a particular medical service and the amount that the consumer pays, the buyer has little or no incentive to monitor cost. Referred to as the third-party payment problem, this phenomenon is widely recognized as a major contributor to rising health care costs. Employees view health care as an entitlement that has no maximum, rather than a part of their compensation. The alliances proposed by the Clinton Administration perpetuate the problem. Our plan provides for member participation and cost-sharing provisions which reduce the third party payment problem by making individuals more aware of the costs of health care.
2. The general public has come to use insurance coverage as a health maintenance vehicle, not as protection against catastrophic illness and high costs, as insurance really is intended. The very nature of insurance is that it should protect you from costs you cannot finance from regular expenditures. Yet, we were providing employees with complete coverage every time they got a cold. It is a seldom recognized fact that the \$250 deductible was started in the 1950's. Our plan provides for \$1,000 deductible so that we are not a maintenance plan, but in fact, a safety net. Combining this plan with our first-dollar wellness coverage ensures that individuals receive the care they need.
3. Previously, we did not make our employees pay anything for the insurance they received. We now recognize that modest copayments are effective in reminding people that there is a cost to this service, and we have implemented cost-sharing in our plans.
4. No matter how good we get at keeping our own costs down, we will never truly contain costs while cost-shifting is allowed. Medicare and Medicaid can receive substantial discounts or just impose their rates in our state; larger corporations can negotiate some pretty good deals; the uninsured receive treatment no matter what; and small businesses in our state just opt out of the game and leave us to pay their way indirectly. Oklahoma Steel & Wire and its affiliates are faced with a different medical marketplace. We can't compete with the large players for discounts. And we surely can't continue to pay for the costs they don't cover.

5. Our former and the traditional health delivery system included very few wellness incentives for the covered individuals. To address the issues, we implemented a series of features, including:

- Ten percent discounts for non-smokers;
- Smoking cessation, 100 percent paid for by the plan;
- First-dollar coverage and active promotion of preventive diagnostic screening such as mammograms, prostate exams, pap exams, and bi-annual physicals;
- Excluding wellness programs from individual deductibles; and
- Excluding prenatal care and infant immunization from deductibles.

Through these efforts, we have learned to control our costs, while still giving our employees excellent coverage and contributing our administrative expertise. We want to continue to participate, Mr. Chairman. President Clinton's Health Security Act would take away our option to control our own destiny by forcing us to give up our self-funded plan and our efforts at health promotion and disease prevention. We have deep reservations that a regional alliance would be responsive to the health care needs of our local community. Would the regional alliance contribute money to induce a doctor to come to Madill like we did? Would the regional alliance answer our employees' questions as quickly and as directly? Would my company continue to have the flexibility to create and promote innovative and effective approaches to health care coverage?

I have mentioned briefly some areas of disagreement with President Clinton's plan; I would also like to mention some areas of consensus. The President has introduced a plan for changing the American health care system in the areas of purchasing and financing health care coverage, delivering care, and insuring care. Oklahoma Steel & Wire and its affiliates support the following elements of the Health Security Act and other health reform proposals:

Universal coverage -- As I described earlier, I support universal coverage through a mandate requiring individuals to be covered by insurance through a private or public program. Employers should be required to offer, but not pay for, health care insurance for their employees and dependents. It is no longer tenable for all citizens in this country to fail to be covered. Our current "voluntary," employment-based system has not worked for everyone. I believe that in order to achieve universal coverage, every employer and individual must participate. No one should "free ride" on the payments of others. No individual or company should be allowed to "opt out" entirely. We think that if small companies won't pay for coverage, individuals should have to cover themselves. In other words, we support an individual mandate to purchase coverage combined with an employer mandate to offer access to coverage.

If we wish to ride the train -- in this case, do business in America -- we must all buy a ticket. And if some cannot afford the price of a ticket, we must all share in covering needy individuals and small, low-wage companies. We also support the notion that there are problems that are the responsibility of society and government has an appropriate role in providing health care to those who are incapable of providing for themselves.

Purchasing reform -- A major inequity in the current system is the uneven spread of risk and costs among payers. Those payers that are large enough, i.e. the Medicare or Medicaid programs and some corporations, have been able to obtain significant discounts in their purchase of health care insurance coverage for their populations. Other smaller and less aggressive purchasers have either paid full retail or withdrawn from the market completely. We accept the premise that all must participate, and we support the proposal that small companies should be able to pool their buying power on a voluntary basis to negotiate purchase of coverage more effectively.

We support the concept of purchasing pools as long as they are voluntary, available to all employers and individuals, and accountable to the participating employers and individuals. Purchasing pools (or alliances) help promote cost conscious buying for companies and individuals. This includes telling people what health care costs, pegging premium contributions to cost effective buying, and providing rewards for consumers and companies that buy wisely.

Promoting health and preventing disease -- Many of the elements of President's plan are designed to promote health and prevent disease, and we applaud them. We support a benefit package that requires all plans to provide certain preventive interventions, to be provided outside copay and deductible requirements. While we support the emphasis on prevention in the President's plan, we are concerned that some incentives for promoting health in the workplace may be lost if employers like Oklahoma Steel & Wire are no longer responsible for managing the health benefits of their employees. We feel it is a moral obligation to take care of your health. As I outlined above, we offer opportunities to encourage our employees to stay healthy in every way we can. If we pay a regional alliance and its plans to keep our employees healthy, we fear that their programs will not be as innovative and certainly not as accessible to our employees as the ones we currently provide. In a regional alliance, we simply write checks to pay for coverage. We lose our control and our ability to exercise our creativity and expertise.

Financing reform -- There can be no fundamental reform in the way we buy coverage without changing the way we pay for it and making individuals more sensitive to costs. Most other countries pay for health coverage through some sort of social insurance or taxation method. We think the voluntary, employment-based system, despite some flaws, is the best way to approach financing in this country. Whatever we do, however, we must design a system that has effective cost containment and provides a progressive and equitable financing mechanism. One means of making individuals aware of costs and instituting containment would be to limit the amount of insurance coverage an individual could exclude from income. Coverage beyond the basic package I described above should be included as income to an individual for tax purposes.

Delivery system reform -- The health care delivery system is changing, even in our community. Rural America faces special challenges in health care delivery. Some of the change has been good. For example, new technology links our local hospital to sophisticated teaching hospitals miles away. But some of the change means that doctors and nurses just don't want to come and practice in our areas anymore. We support plans to provide additional funding for training primary care physicians, expanding the training of nurse practitioners and physician assistants, and providing access to capital for young doctors just starting their practices.

We doubt that there will be too much competition in Madill, Norman, or Centerville. We would welcome the addition of so many doctors that they would be fighting over patients. Right now, our problem is just the opposite. Doctors have more patients than they can treat. Our problem is that our doctors don't earn enough to want to come and practice in our small communities. Managed competition is just a theory to us, a theory that is unlikely to work well with a lack of providers. We would welcome the additional federal monies that are proposed for rural, underserved areas such as ours.

Insurance reform -- Within the past year, a strong consensus has developed for the reform of insurance practices in health care, not just in our company but across the nation. We support the elimination of pre-existing conditions; modified community rating to create a more level playing field; and simplification of billing and reimbursement procedures so that single forms and processes are implemented industry wide. All these elements of insurance reform can be found in the President's plan and in all of the other plans introduced in Congress. Overall, health insurance must be portable so that job loss or change does not deprive a worker or family of health care coverage.

Malpractice reform -- We have been frankly disappointed that the President's plan for dealing with malpractice costs does not place a cap on damages. We don't want to deprive people who have been seriously injured from getting their compensation. But we do want to discourage people (and their lawyers) from the insupportably large awards that come from a greedy system and the lack of equity in the awarding of those damages. We also want doctors to treat and prescribe, as clinically necessary, not to avoid getting sued.

While we can agree with the President and many members of Congress about the importance of passing health care legislation as soon as possible, we also wish to share our concerns about certain aspects of reform. Some of these concerns relate to the specific issues I raised at the beginning of my testimony.

Mandatory nature of the regional alliances -- Our major concern is loss of control over our own benefit and health programs. Oklahoma Steel & Wire is too small to qualify as a corporate alliance under the Clinton plan. We would have no choice except to turn over our health benefits management to the regional alliance. We understand that mandates are important to ensure that everyone is covered; we disagree that there is any absolute size threshold under which employers are too small to manage their own plans. Joining an alliance should be an option, not a requirement. If the regional alliance is as effective as the President proposes, then no one should doubt that employers will want to join it. Shouldn't it tell you something, however, when employer after employer comes before you to tell you they do not believe that government can run this program better than they can?

Generosity of the benefit package -- The benefit package as currently proposed is too comprehensive and the cost-sharing would not deter over-utilization by consumers. Insurance should be a safety net. The benefit package as designed would drive up utilization considerably with little individual understanding of the costs of health care. Moreover, if a consumer need only spend \$1,500 to reach a maximum annual out-of-pocket ceiling, there is little incentive for utilization control and from going to providers in a managed care network after reaching the annual ceiling.

Coverage of retirees -- While covering retirees would be a big help for our retirees and for any company that faces the costs of covering the over 55 population, we seriously doubt that the government can afford to follow through on its generous offer. We could not support a government subsidy of this magnitude until after there has been a thorough debate on the cost of covering retirees. A more modest proposal would be a great help to our retirees -- allow them to purchase coverage without being rejected for pre-existing conditions, or to join an HMO where one is available. We hope that the Medicare program will reverse its current curious stance toward managed care for Medicare recipients.

Financing of the program -- We have little confidence in the numbers we have seen. I fear that with the history of medical inflation rates, it will be very difficult to keep costs under control in any system we devise. There is no guarantee that the payroll cap would stay at 7.9 percent. Effective tools to contain costs are missing. There are some surprising inconsistencies in the President's package: employer contributions to the insurance premium are tax deductible, though employee contributions are not. Tax advantages are not linked to the lowest cost plan, thus muting incentives for cost containment. Benefits provided beyond the standard package and the purchase of any plan that costs more than the lowest cost plan should be subject to taxation. Plans should compete to be the lowest cost plan offered, not just the average cost plan. We support managed competition. Implement the concept so that it can work the way the theory is designed to work.

Employment impact -- The Administration assures us that only -- now I say only -- 300,000 some jobs will be lost as a result of this plan. The fact is no one can really quantify the impact of the administration's plan as proposed. But I can assure you of one thing -- if enacted as proposed, there will be a tremendous additional pressure to reduce the number of employees required for a given function. Each employee will represent a growing potential liability. Employee benefits are part of total compensation. The Clinton plan greatly increases the fixed costs of hiring.

Bureaucratic nature of the alliances -- The way regional alliances have been constructed, as public or quasi-public and very political entities, dooms them to failure as responsive arbitrators of coverage. They will not be responsive to Madill and Norman, Oklahoma.

In relation to the concerns I have raised, I would like to offer some solutions which I believe would be consistent with the principles of universality, simplicity, equity and quality, while also taking into account the realities of doing business in Oklahoma and Iowa. I recommend a series of changes to the way we purchase and deliver health care that should be implemented in a slightly longer phase-in period and would take advantage of the creativity currently operating.

- * Allow companies to elect to form a corporate alliance or to join the regional alliance and to make their own decisions about self-funding and administration of their health care plan irrespective of the number of employees they have.

- * Create the opportunity for all employers to band together voluntarily in buying pools. There are over 150 active business coalitions around the country, many of which have negotiated common benefit packages. The Health Security Act appears to deny companies the opportunity and the right to create these business coalitions. While we understand the need to mix risk in regional alliances, we strongly support the right of individual companies to join together to purchase insurance coverage more effectively.
- * Provide a mechanism that assures universal coverage which mandates universal participation in a public or private system.
- * Mandate health care to be "portable" so that job loss or change does not deprive a person or family of insurability. Eliminate pre-existing conditions.
- * Offer choice of plans and providers to employees, and allow the flexibility to offer only managed care plans. Why force corporations to go back to indemnity plans when point-of-service options within managed care plans offer the same degree of choice for individuals with added simplicity of administration?
- * Provide companies that operate on-site wellness programs and other health promotion programs the opportunity to apply for premium discounts or receive other financial incentives for promoting these programs.
- * Continue ERISA protection for self-funded plans.
- * Eliminate favorable tax treatment of excess benefits. Individuals who wish to buy more coverage should buy it with after-tax dollars.

Thank you, Mr. Chairman, for this opportunity to present my views on health care reform legislation. I look forward to the opportunity to discuss my recommendations further and to participate in this important policy debate. I will be happy to answer any questions you and the other Committee members have.

Mr. JACOBS. Mr. Hoagland will inquire.

Mr. HOAGLAND. I have no questions, Mr. Chairman, thank you.

Mr. JACOBS. Mr. Santorum.

Mr. SANTORUM. Thank you, Mr. Chairman. Since I do have some time, I will followup on the medical savings part of it with Mr. Kushner.

Are you a supporter of the medical savings account? Are you familiar with the plan?

Mr. KUSHNER. I am familiar with it in broad terms of the plan.

Mr. SANTORUM. Are you supportive of it?

Mr. KUSHNER. SHRM would support more of that approach to health care than perhaps some of the others that have been offered.

Mr. SANTORUM. Mr. Moore, I just very quickly was trying to read your testimony as you were testifying. It seems to me that the concept you were employing is pretty similar to medical savings accounts—higher deductibility, more involvement of employees with the cost of their health care.

Mr. MOORE. Absolutely. We have a problem, the third—the third-party pay problem absolutely exists in this country, which has contributed to the runaway costs that we have experienced.

Mr. SANTORUM. Are you familiar with medical savings accounts?

Mr. MOORE. No, I am not.

Mr. SANTORUM. We have got to get you familiar.

I will ask Ms. Kelley. You were going through all the problems in the plan, the Clinton plan. Are you familiar with medical savings accounts?

Ms. KELLEY. No, sir, I am not.

Mr. SANTORUM. We aren't doing a very good job here, Bill and Andy. But let me very briefly describe what it is. It is a concept where you have increased deductibles and saving, the premium savings are given to the employee in the form of a tax-free distribution, similar to a 401(k) plan. And the money is used tax free for expenditure on medical care to meet your deductible. Any money not spent is kept by the employee in this account as a savings.

Very quickly, do you see any horrible complications in payroll administration, a plan of that nature?

Ms. KELLEY. Sir, we will have to look at that before commenting. The administrative—as our testimony speaks, the processes that we have to go through are not simple. And the data banks that we build and the systems that we provide information reporting to—

Mr. SANTORUM. If we provided you—Mr. Jacobs and Mr. Archer are cosponsors of a medical savings account bill. And it is in—I believe, Bill, is not the medical savings account in all of the Republican plans that have been introduced?

Mr. THOMAS. Yes, all of the plans that have been introduced have a component which does not mandate but allows an option to utilize a high catastrophic; and the dollar that would otherwise be spent for the insurance is held in that tax-free account to be spent for medical purposes. If it isn't all consumed, it is rolled over to be used for medical purposes, hopefully to build up a self-insurance structure, Mr. Moore.

Mr. SANTORUM. We would appreciate it, if, we get you that information, you will give us some testimony.

Thank you, Mr. Chairman.

Mr. JACOBS. Mr. Brewster.

Mr. BREWSTER. Mr. Chairman, I believe Mr. Moore's plan is something like a medical savings in one respect, in that it is my understanding, Max, that at the end of the year a certain amount of the money that if it has not been used is given to the employees in the form of bonuses. Is that not correct?

Mr. MOORE. We intended, fully intended to share 25 percent of our savings, which was over 50 percent of our traditional plan, we intended to give 25 percent of those savings back to our employees. Unfortunately, we were precluded from doing that—we were going to share the savings back to our employees on a proportional basis of what they had been involved in and what the company had been involved in, paying the original premiums.

Unfortunately, we were precluded from doing that because of the cafeteria rules established in government. And we were forced then to give an equal amount to all employees, which we, in fact, did.

But had we been able to do it the other way, we would have been able to give more to those employees who contributed more, and we would have been able to penalize those who were smokers, which our plan provides for—nonsmoking discounts—and where we promote the health, the wellness issues, because that is the ultimate way to hold our health care costs down.

We are just business people trying to do a good job.

Mr. BREWSTER. Couple of other points. You mentioned universal coverage. Do you feel that because 30-something million people—the numbers vary—don't have coverage today, that there is cost-shifting going on that is requiring your people to pay more in many cases?

Mr. MOORE. Absolutely. There is cost-shifting going on from the Medicare system, the Medicaid system, those that are poor and unable to pay for their coverage.

In Madill, Oklahoma, we had a doctor that had a 40 percent bad debt ratio, a 40 percent bad debt. And then on top of that, because he was in the rural communities, the Medicare-Medicaid cut his amount of money that he received because he was in the small rural areas.

This is impacted—the rest of us who have to pay the bill here.

Mr. BREWSTER. One more question before my time runs out.

If you could opt out, if your business could opt out, where under the current Clinton plan they could not because of the numbers requirement, would you be supportive of the plan if you could opt out of it?

Mr. MOORE. I would not—I think from our standpoint and the rest of industry and business' position, you have to allow us to control our own destiny. But I think there are certain areas that still need to be addressed in the administration's proposal that I do not favor, but the primary one, to us, is that we have to be able to manage our own affairs instead of allowing a government bureaucrat to manage them for us.

Right now, our health care costs are 3.6 percent. When someone says 7.9 to us, that is a significant amount of money. And that is only going to be offset in either reduced jobs or reduced wages.

Mr. BREWSTER. Thank you.

Mr. JACOBS. Mr. McCrery.

Mr. MCCRERY. Very quickly, Mr. Moore, in following up on Mr. Brewster's question—if you could opt out, would you support the President's plan—I think I heard you say a few minutes ago that the third-party payment system was part of the problem in this country for escalating costs. Is that correct?

Mr. MOORE. Absolutely.

Mr. MCCRERY. Do you see anything in the President's plan that would reduce the influence of the third-party payment system on our health care system?

Mr. MOORE. The—well, first, I will answer that question, then I will get back to the other.

The President's plan as currently proposed only exacerbates the problem. It makes it a lot worse.

Mr. MCCRERY. If that is true and you think that is the problem, then why on earth would you even think about supporting the plan if you could opt out? Because the prices in the system are going to affect your prices regardless of the management technique you use.

Mr. MOORE. If I could opt out, it would make it much more palatable for my individual system, but as—but as far as supporting it for the whole country, no.

You have got to address—you have got to allow individuals—you have got to force individuals, the 250 or 275 million people that are in this country, to recognize that health care is a cost, it is not an entitlement.

Mr. MCCRERY. Exactly. Thank you, Mr. Moore.

Mr. JACOBS. The committee thanks the panel for your contributions to the record; you have been helpful. And this panel is excused.

Mr. JACOBS. If the next panel would come forward and take seats, we will recess the committee long enough to cast this vote. We will be back as quickly as possible.

[Recess.]

Mr. JACOBS. You may begin.

STATEMENT OF JUDITH L. LICHTMAN, PRESIDENT, WOMEN'S LEGAL DEFENSE FUND

Ms. LICHTMAN. My name is Judith Lichtman. Thank you very much for hearing us today.

I am the president of the Women's Legal Defense Fund. If health care reform builds on our current employer-based system, the Women's Legal Defense Fund supports a requirement that employers contribute to a minimum health benefit to ensure health care security for millions of working women and their families who fall through the cracks of the current system.

In the context of health care reform that builds on our current employer-based system, requiring employers to contribute to their employees' premiums is essential to achieve universal coverage. The current system doesn't work for the millions of women who work in low-wage, part-time, temporary, service-industry and small-firm jobs; jobs that typically don't offer health insurance. These women and their families are suffering under the current system.

The time is ripe for Congress to remedy the gaps in the current employer-based system by enacting a minimum labor standard as previous Congresses responded to other social problems by enacting Social Security, fair labor standards, safety and health, and most recently, family and medical leave. This can be done.

Throughout history, Congress has enacted minimum labor standards when three conditions are met. A serious social problem affecting workers and their families must be directly addressed. Voluntary corrective action on the part of employers have proven inadequate, and when the law establishes a standard that employers can meet, based on our experience as the leader of the national coalition that advocated for family and medical leave, we are convinced that the same historical conditions are met here with health care.

The health care needs of workers and their families is a serious social problem that must be addressed. Voluntary corrective action by employers has proven inadequate. And a minimum health benefit requirement is a standard that employers can meet.

First, the serious social problem. The health care crisis must be addressed. Sadly, the number of workers who are uninsured is increasing while health care costs remain high for employers and employees. Uninsured health care expenses drain individual families financially and emotionally and drain our Nation's economy, decreasing our global competitiveness.

Second, voluntary corrective actions by employers have proven inadequate. Workers and their families make up eight out of ten people without health insurance, and indeed many employers increasingly opt for a contingent work force just to avoid the payment of health benefits.

Third, like family and medical leave and other minimum labor standards, the Health Security Act's minimum health benefit provisions establish standards that employers can meet and can provide workers and their families with health security.

Mr. JACOBS. Miss Lichtman, your third minute has expired also. Perhaps if other members come in, Mr. Santorum is here—more will be brought about, but we have people at the end of the line that are about to miss airplanes, the others should be on time anyway.

[The prepared statement follows:]

TESTIMONY OF
JUDITH L. LICHTMAN,
PRESIDENT OF THE
WOMEN'S LEGAL DEFENSE FUND,
BEFORE THE COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
ON THE
EMPLOYER MANDATE PROVISIONS
OF THE
HEALTH SECURITY ACT, H.R. 3600

FEBRUARY 3, 1994

Mr. Chairman and Members of the Committee, I am Judith L. Lichtman, President of the Women's Legal Defense Fund, which has worked to promote women's equality since 1971, particularly in the areas of employment, health, and family economic security. Thank you for the opportunity to speak to you today about the "employer mandate" provisions of the Administration's proposed Health Security Act (H.R. 3600).

If comprehensive health care reform builds on our current employer-based system of providing health insurance, we firmly believe that requiring employers to contribute to the cost of basic health care for workers and their families is essential to achieve universal coverage. This requirement is especially critical for working women who all too often do not receive health insurance coverage through their employers.

Since many working women are concentrated in the kinds of jobs that do not offer health insurance coverage, the existing employer-based system simply does not work for working women and the families who depend on them. Any effort to reform our current system must remedy this most glaring failure. Indeed, history teaches that this is precisely the situation -- and precisely the moment -- that calls for Congress to enact a minimum labor standard to address this problem so that employer-based coverage is guaranteed for all workers.

WORKING WOMEN ARE CONCENTRATED IN JOBS THAT DO NOT PROVIDE
HEALTH INSURANCE COVERAGE

Contingent Workers

Women comprise most of the growing "contingent" workforce in the U.S., which at an estimated 3.9 million employees is the fastest growing segment of our labor force. Contingent workers include part-time, temporary, contract and casual employees. The Bureau of Labor Statistics reports that over two-thirds of all part-time workers are women; twenty-five percent of all working women work part-time. More than three-fifths of all temporary workers are women.¹

Some women work part-time because it is the only way to balance family and financial responsibilities. However, a great many women work part-time involuntarily -- that is, they would prefer to work full-time. Over 40% of part-time workers work part-time involuntarily, and women are 44% more likely than men to be involuntary part-timers.² Since contingent jobs are typically low-wage, it is not uncommon for many women to hold multiple part-time jobs simultaneously just to make ends meet.

Whether they are forced to work part-time or choose to do so, legions of contingent workers lose out on the benefits that are often taken for granted in full-time employment - benefits that include seniority-based compensation, pensions, and most important, health insurance. Only 23% of temporary employees and 22% of part-time

¹ Economic Policy Institute, New Policies for the Part-Time and Contingent Workforce (Virginia L. duRivage, ed. 1992) (hereinafter, "EPI, New Policies").

² EPI, New Policies.

employees receive health insurance benefits through their employers.³ Moreover, just last week, the Bureau of Labor Statistics reported that only 5% of part-time workers in firms with fewer than 100 employees have employer-provided health care coverage.⁴

Low-Wage/Service Sector Jobs

In addition, even if they work full-time, women on average work for lower wages than men and are more likely to work in jobs that do not carry health insurance benefits. Women are disproportionately represented in jobs paying \$20,000/year or less: nearly 70% of all women workers earn less than \$20,000/year and 40% of all women workers earn less than \$10,000/year.⁵ New data shows that 32% of U.S. workers earning less than \$10,000/year lack health insurance coverage of any kind. A full 88% of the uninsured are in families with an estimated adjusted gross income (AGI) of less than \$20,000/year.⁶

Women are the majority of workers in the growing service-providing industries and in smaller firms, which have the lowest rates of providing benefits. For example, women hold more than 52% of the nation's retail trade jobs and 62% of service industry jobs (working in industries such as hotels, personal services, educational and social services, and health services).⁷ A typical service sector job is in a small-sized firm, pays little better than minimum-wage, and does not provide health insurance coverage. Thirty percent of all employees working in firms with fewer than 10 employees are uninsured.⁸

It is these low-wage workers -- contingent workers, service industry workers, and those in small firms -- who can least afford to buy health insurance for themselves and their families without employer assistance.

GAPS IN OUR EMPLOYER-BASED SYSTEM

The crisis is clear. Too many women -- both contingent and full-time workers -- are falling through the cracks of our current employer-based health care system. As more and more employers opt for contingent work arrangements or decrease coverage for full-time employees to cut costs, more and more employees -- women and men -- will suffer the consequences of the health care gap. A requirement that employers contribute to the costs of providing health care coverage for all employees -- including part-time employees -- and their families would close the gap. Such a requirement would provide health security for millions of working women and their families who now live without basic health care and would begin to alleviate some of the economic inequities faced by women workers.

CONTINGENT, LOW-WAGE AND SMALL FIRM WORKERS WOULD BENEFIT FROM THE EMPLOYER REQUIREMENTS IN THE HEALTH SECURITY ACT

The HSA's requirement that all employers contribute to the health insurance premiums of employees who work at least 40 hours in a month will vastly improve our current employer-based system for contingent and low-wage employees, particularly

³ EPI, New Policies.

⁴ U.S. Department of Labor, Bureau of Labor Statistics, reported in Daily Labor Report, No. 18, p.B-7 (January 28, 1994).

⁵ U.S. Department of Commerce, Bureau of the Census, Current Population Reports, Series P60-184, Money Income of Households, Families, and Persons in the United States: 1992.

⁶ Employee Benefit Research Institute, Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1993 Current Population Survey (January 1994) (hereinafter "EBRI, Sources of Health Insurance").

⁷ U.S. Department of Labor, Bureau of Labor Statistics, Employment and Earnings (January, 1991).

⁸ EBRI, Sources of Health Insurance.

benefiting women workers. Under HSA, most part-time, temporary, and low-wage workers would be assured some amount of employer contribution toward health insurance.

The Act requires employers to make pro-rated contributions toward health insurance premiums for part-time employees, based on the number of hours worked per month. Although part-time workers would be required to pay some part of the employer's unpaid share, HSA's income-based caps would kick in to limit the total amount most part-time workers would have to pay towards their premiums. An exception to this rule is part-time employees who work less than 40 hours per month for one employer. Such day workers or casual laborers would generally be responsible for the entire employer share (in addition to the family share), subject to income-based caps. Temporary workers also stand to gain significantly under the Act because they would be considered employees -- either part-time or full-time -- of the temporary agency that hires and places them, so the agency would be required to contribute to the employee's premium.

The HSA would also cover seasonal workers in the same way as part-time or full-time employees, with employers obligated to make contributions based on the number of hours worked per month. However, there are some ambiguities concerning HSA's coverage of seasonal workers. The nature of seasonal work -- with erratic work schedules that fluctuate widely from month-to-month (particularly for agricultural workers who move from employer to employer within a season of employment) -- may mean these workers would fall through the cracks without any employer contributions.

A major problem with the HSA's employee coverage provisions is its failure to define "employee" broad enough to cover people who are currently classified inappropriately as independent contractors. Since this classification makes a significant difference under the plan in terms of who contributes and how much, the legislation should make the definition clear, and should ensure that "independent contractor" status does not operate to deny coverage to workers who are truly employees.

IN THE CONTEXT OF REFORM OF THE U.S. EMPLOYER-BASED SYSTEM, IT IS APPROPRIATE FOR CONGRESS TO ENACT A MINIMUM LABOR STANDARD THAT REQUIRES EMPLOYERS TO MAKE REASONABLE CONTRIBUTIONS TO THEIR EMPLOYEES' PREMIUMS

Our support for an employer requirement in the context of legislation that builds on the current employer-based system is grounded in our experience as the chair of the national coalition to pass the Family and Medical Leave Act (FMLA). This coalition consisted of more than 250 national organizations, including civil rights representatives, employers, religious organizations, health care providers, educators, disability rights advocates, senior citizens' representatives, children's and parents' advocates, labor unions, and women's rights advocates.

The FMLA requires employers to provide workers with job-guaranteed leave to help them balance work and family responsibilities. Just as in the current debate about health care reform, detractors of the FMLA labelled it an unnecessary and burdensome "employer mandate."

As the debate developed throughout the eight-year campaign to enact the FMLA, changing economic circumstances and workplace demographics compelled Congress to enact the FMLA as a minimum labor standard -- job guaranteed leave at times of family or medical emergency -- to meet the needs of working families. Just as earlier Congresses enacted minimum labor standards in the form of laws regulating child labor, minimum wages, occupational health and safety, pension and welfare benefits and anti-discrimination laws, the FMLA too established a minimum labor standard to respond to the particular problems facing working families that had broad social implications.

Our research during the FMLA revealed that, throughout our history, Congress has enacted minimum labor standards when three conditions were met:

- 1) a serious social problem must be directly addressed;
- 2) voluntary corrective actions on the part of employers have proven inadequate; and
- 3) the law establishes a standard that employers can meet.

In the case of the FMLA, Congress was satisfied that these conditions were met: First, the serious social problem caused by crises in working families had to be addressed; second, employers' voluntary corrective actions did not adequately address that problem; and third, the FMLA established standards that employers can meet.⁹ Much like the Fair Labor Standards Act, the Occupational Safety and Health Act and the Social Security Act, the minimum standard enacted by the FMLA will be widely accepted as a basic right of workers and a basic responsibility of employers. It is worth noting that the same special interest business lobby that vehemently opposed enacting any employer mandates to establish social security, fair labor standards, and safety and health laws, for example, are the same interests that resist establishing minimum health benefits now.

Based on our experience with the FMLA, we are convinced that the same conditions exist with respect to health care. First, a serious social problem - the health care crisis - must be addressed. The number of workers who are uninsured is increasing while health care costs remain high for employers and employees.¹⁰ The negative effects of this crisis are manifold - from the financial and emotional drain on families struggling to obtain health care to the drain on our national economy and hence our global competitiveness. Second, voluntary corrective actions by employers have proven inadequate. Workers and their families remain uninsured and, indeed, many employers increasingly opt for a contingent workforce just to avoid the payment of health benefits. Third, like the FMLA and other minimum labor standards, the Health Security Act's minimum health benefit provisions establish standards that employers can meet. Experience shows that employers who already provide health insurance for their employees are paying too much -- precisely because they also bear the costs for those employers who do not. Insurance companies raise their premiums to cover the cost of care to the uninsured. The Act requires all employers, in concert with employees, to make reasonable contributions toward their employees' premiums. Further, the Act generally addresses part-time employees in a fair and equitable manner; employers with part-time employees will make pro-rated contributions. In addition, the Act specifically takes into consideration the needs of smaller businesses by capping the amount of employer contributions based on the percentage of payroll, thus subsidizing their participation.¹¹

Moreover, studies show that employers benefit economically when their employees have adequate health care. For example, the March of Dimes reports that

⁹ See Report of the House of Representatives Committee on Education and Labor, No. 103-8, 103rd Cong., 1st Sess. (1993) at 21-22 and Report of the Senate Committee on Labor and Human Resources, No. 103-3, 103rd Cong., 1st Sess. (1993) at 4-5.

¹⁰ Government data show that the number of uninsured people in the U.S. reached 38.9 million in 1992, an increase of 4.2 million from 1989 and 2.3 million from 1991. EBRI, *Sources of Health Insurance*. Total health expenditures rose more than 10% in 1993. "Yes, There is a Health Crisis," *The New York Times* (January 30, 1994), p.E16.

¹¹ A recent analysis of the economic impact of the health care plan on manufacturing indicates that employers will not be forced to cut jobs due to the employer requirement; in fact, the study projects that the substantial savings due to redistribution of health costs and cost containment will result in a net increase of jobs. See Russell, Baker & Tung, "The Impact of the Clinton Health Care Plan on Jobs, Investment, Wages, Productivity and Exports," (Economic Policy Institute Briefing Paper 1994).

poor birth outcomes cost employers and employees \$5.6 billion in 1990 alone. However, when employers provide coverage for prenatal care for their employees, which reduces the likelihood of premature and low-birthweight babies, they realize immediate savings in health care costs as well as the long-term financial benefits of a healthy, productive work-force.¹²

In addition, studies conducted by the Kaiser Family Foundation demonstrate that uninsured people receive less medical treatment, are sicker and suffer higher mortality rates than those covered by insurance. Requiring employers to contribute toward coverage for all employees will actually reduce the amount employers are now paying for extra sick time and turnover or replacement costs for employees who currently go without health insurance.¹³

Finally, new data indicate that reforming the current employer-based system will save employers over \$25 billion each year by 2000. According to Administration estimates, employers with fewer than 5000 employees would spend only 6.5% of payroll on health care costs under the HSA, compared to 8.2% of payroll if no reforms are made.

Conclusion

The need for universal coverage to address the failures of our current employer-based system is critical -- particularly for working women and their families. The question to be asked in health care reform is the same as the one answered by the FMLA: Do the preconditions exist for enacting a minimum labor standard to universalize health care in America? The answer is yes.

¹² March of Dimes Birth Defects Foundation, *Healthy Babies, Healthy Business: An Employer's Guidebook on Improving Maternal and Infant Health* (1994).

¹³ Studies cited in "Yes, There Is a Health Care Crisis," *The New York Times* (1/30/94), p. E16.

**STATEMENT OF ANN KOLKER, DIRECTOR, PUBLIC POLICY,
NATIONAL WOMEN'S LAW CENTER**

Mr. JACOBS. Our next panelist is Ms. Kolker and you are recognized for 3 minutes.

Ms. KOLKER. Thank you very much. I am Ann Kolker, director of public policy at the National Women's Law Center, and with me is Kara Andersen, staff counsel.

As Congress considers fundamental change in the health care system, the health needs of all Americans including women must be addressed. The crisis for women, as Ms. Lichtman outlined, is real and serious. We believe that comprehensive, not incremental, reform is essential to ensure universal coverage, comprehensive benefits, and cost effective and affordable care that will make health security a reality for American women.

Because our current system allows, but does not require employers to contribute to the health premiums of their employees, the security that health insurance provides continues to elude even many working individuals. We know that over half of the uninsured are in families headed by a full-year, full-time worker.

We believe that a mandate that all employers provide health insurance for workers and their dependents is a very large and important step toward providing that security for many women.

Indeed, as we have seen from Hawaii's experience where an employer mandate has been in effect for the past two decades, this approach ensures coverage for approximately 95 percent of the population.

Under an employer-based system, however, where workers are required to pay a portion of the premium, the level of the premium contribution is key. For women whose wages continue to be approximately 30 percent less than men's, health insurance must be affordable. Anything less than the 80 percent share required by the Clinton plan could impose real hardship on many working women and their families because under our current system employed women are less likely to receive employment-based health insurance than employed men.

A mere 37 percent of employed women have health insurance through work compared to 56 percent of employed men.

As Ms. Lichtman outlined, women are represented in low-wage jobs, in the service and retail trade industries, and women constitute the majority of part-time workers who are only one-third as likely to have health insurance coverage as full-time workers.

Another problem is that women are more likely than men to be insured as dependents, comprising 72 percent of those who rely on dependent coverage. We know also that women on welfare risk losing their health insurance when they join the work force because many of the jobs for which they are most qualified, are low-skilled jobs that typically do not provide health insurance.

I would like to conclude by reminding the committee that opponents of reform often claim that changing the status quo will lead to disaster. In 1935, when Congress was debating whether or not to enact Social Security legislation, pundits claimed that imposing directly upon industry such a tremendous burden would create a reaction which would cause the depression to be indefinitely prolonged.

Of course the Social Security Act was passed despite such protests and has proved to be one of the great pieces of social legislation in this country.

You have an opportunity to make your mark on history and we hope you will do so by enacting the Health Security Act, or an act which achieves similar goals.

Mr. JACOBS. The committee will take note of history.

[The prepared statement follows:]

TESTIMONY OF ANN KOLKER and KARA ANDERSEN
 NATIONAL WOMEN'S LAW CENTER
 BEFORE THE COMMITTEE ON WAYS AND MEANS
 U.S. HOUSE OF REPRESENTATIVES
 ON
 THE HEALTH SECURITY ACT AND THE EMPLOYER MANDATE

February 3, 1994

Mr. Chairman and members of the Subcommittee, I am Ann Kolker, Director of Public Policy/Health and Reproductive Rights at the National Women's Law Center. With me is Kara Andersen, Staff Counsel at the Center. We appreciate the opportunity to appear before you today.

The National Women's Law Center is a non-profit organization that has been working since 1972 to advance and protect women's legal rights. The Center focuses on major policy areas of importance to women and their families including health care reform, reproductive rights, employment, education, family support and income security -- with special attention given to the concerns of low-income women and their families.

National health care reform is a major concern and priority of American women. As Congress considers fundamental change in the health care system, the health care needs of all Americans, including women, must be addressed. It is essential that the system be designed to provide universal coverage, comprehensive benefits, and cost-effective and affordable care and that the special needs of women be considered throughout the deliberation process.

Our testimony today will address the first of these important criteria, universal coverage, because we have been asked to discuss the employer mandate -- the vehicle proposed by the President's Health Security Act to achieve universal coverage. While we support this approach as a means of guaranteeing health security to all Americans by building upon our current system, we also acknowledge that other schemes, such as a single payer model, would satisfy our objective of guaranteed universal coverage as well. Indeed, important as an employer mandate is, it does not do the job of providing universal coverage as completely as a single payer system, particularly for women whose income is from non-wage sources such as pension or alimony, because everyone -- worker and non-worker, child and adult -- is covered in the same manner. With the Health Security Act currently at the center of national debate, however, today we will discuss the relevance of an employer mandate for women -- including women in the labor force, women dependent on another worker in the family for their health insurance, and women who rely on Medicaid. We will also describe some lessons learned from our work on family and medical leave, another employer-mandated benefit.

I. Our Current System Fails to Provide Health Security to Women and Their Families

Our current system of health care coverage is really a patchwork of several different systems:

- > 62.5% of nonelderly Americans have employment-based health coverage;
- > 15.1% rely on publicly-funded health insurance;
- > 8.5% purchase private insurance on their own; and
- > 17.4% -- almost 40 million Americans -- lack health insurance of any kind.¹

Although the employment-based system -- which covers the majority of Americans -- provides coverage for many, it is far from adequate. Because our current system allows, but does not require, employers to contribute to the health care premiums of their employees, the

¹ Employee Benefits Research Institute ("EBRI"), Sources of Health Insurance and Characteristics of the Uninsured, January 1994, at 5.

security that health insurance provides continues to elude even many working individuals. The majority (52.4%) of the uninsured are in families headed by full-year, full-time workers.² Moreover, even those fortunate enough to have employment-based coverage are at risk of losing their insurance at any time due to employer cut-backs, or if they leave their job. In short, today's employment-based system fails to guarantee true health security. A mandate that all employers provide health insurance for their workers is a very large and important step toward providing that security for many women. Indeed, as we have seen from Hawaii's experience, where an employer mandate has been in effect for the past two decades, this approach ensures coverage for about 95% of the population (the estimates vary somewhat).

It bears emphasizing, however, that under an employer-based system, where workers are required to pay a portion of the premium, the level of this contribution is key. For women, whose wages continue to be 30% less than men's, health insurance must be affordable. Thus, a generous employer contribution is critical. Anything less than the 80% share required by the Clinton plan could impose real hardship on many working women and their families.

A. Employed Women are Less Likely to Receive Employment-Based Health Insurance than Employed Men

Women are particularly vulnerable under our current system. They are one-fourth less likely than men to receive health coverage directly through an employer.³ Indeed, a mere 37% of employed women have health insurance coverage through work, compared to 56% of employed men. The reasons for this alarming disparity are manyfold.

1. Women are Disproportionately Represented in Low-Wage Jobs

First, women workers are disproportionately represented in the jobs paying under \$20,000 per year where virtually all the uninsured workers (88%) are concentrated. For example, nearly half of all working women earn under \$10,000 and a full 80% of working women earn under \$20,000 compared to half of men. By offering the same health care benefits to all employees, regardless of income, an employer mandate would constitute an important step toward redressing the injustices women suffer by being relegated to low-wage jobs. The employer mandate would finally put to rest the catch-22 situation of forcing those working individuals who can least afford it to incur the entire expense of their health insurance, or to forego such coverage altogether.

2. Women are Concentrated in the Service and Retail Trade Industries

Second, women workers are concentrated in the very industries which have the lowest rates of health benefits. For example, over one-half of all uninsured workers are employed in the female-dominated trade and service sectors. Service workers, 61.7% of whom are women, constitute nearly one-quarter of all uninsured workers. In retail trades, where more than half of the workers are women, 58.3% of workers receive health insurance through their employer. By contrast, in wholesale trades, where nearly 70% of the workers are male, employer-provided insurance covers nearly 80% of all workers. Again, by requiring all employers to contribute to their employees' health care premiums, an employer mandate would provide long-overdue health insurance to a group of workers -- predominantly women -- who have historically been denied a benefit provided to many other employees.

3. The Majority of Part-Time Workers are Women

Finally, women comprise over two-thirds of the part-time work force -- a group only one-third as likely to have health coverage as full-time workers. Many part-time

² *Id.* at 9.

³ *Id.* at 50.

women and their families would benefit from an employer mandate, such as that described in the Health Security Act, which requires employers to pay a pro-rated share of the health care premiums for employees who work between 10 and 30 hours per week. Indeed, because the employer's pro-rata contribution is based on a 30-hour work week, the proposed scheme is particularly advantageous to part-time workers. For example, an employer would be required to pay 40% of the health care premium for an employee who worked 15 hours per week (15 hours worked/30 hour work week X the 80% share the employer is required to contribute for a full-time employee). Such a requirement will finally make health care both available and affordable for many who work part time.

For women who work less than 10 hours per week for any single employer, however, the employer mandate is problematic. With no contribution from an employer, these women are left to bear the entire burden of their health care expenses. Although subsidies are available for low-income people, some may still have difficulty obtaining coverage.

B. Women Are More Likely Than Men to Be Insured as Dependents

The employer mandate as detailed in the Health Security Act will also help those who are in the precarious position of relying on dependent coverage, which has been cut significantly in recent years. Not surprisingly, many more women than men receive health coverage as dependents: women comprise 72% of those who rely on dependent coverage.⁴ Individuals who are covered as dependents fall into two categories: those who work but whose employers do not provide health benefits, and those not in the work force. The Health Security Act will help both of these vulnerable populations.

* First, as discussed above, the employer mandate will require those employers who currently do not provide employer-based coverage do so, enabling the many working women who are not insured by their employers to secure coverage in their own right, and to obtain a sense of security they simply do not have when dependent on the employment-based coverage of a family member. Much more than a symbolic improvement, the employer mandate will provide important protection against the risk of losing coverage whenever a spouse loses or changes jobs or in the event of a change in family status.

* Second, even those who are not employed will be guaranteed dependent coverage if they have a spouse who works. Under the Health Security Act, health care premiums vary according to four family types: single individual, couple without children, single-parent family, and dual-parent family. Employers contribute to their employees' premiums based on the family status of the employee. For example, the employer of a married woman with children would pay 80% of the premium amount for a dual-parent family, thus contributing to the health care coverage of the entire family. By building dependent coverage into the employer mandate in this way, the Health Security Act will indeed provide health security to many who live in fear of losing their dependent coverage today. Moreover, the Act prohibits employers from discriminating against an employee on the basis of her or his family status⁵ -- thus providing an added protection to employees with dependents. While commendable, these protections should be strengthened to prohibit discrimination by employers on the basis of an employee's sex, race, national origin, and any other protected status. Although Title VII would cover discrimination in this regard for employers with more than 15 employees, clarifying the prohibition for all in the Act is important.

Reflecting today's reality that many families live in two-earner households, the Health Security Act provides help for employers, particularly those who have been covering the entire family in a two-worker household, by requiring both employers to share in the employer contribution to the family's health insurance premiums. Regardless of the number

⁴ *Id.* at 51.

⁵ Section 1605.

of employers who contribute to a family's premiums, however, the family share will remain constant.

C. Women on Welfare Risk Losing Their Health Insurance When They Join the Work Force

In addition to providing health security to millions of Americans who are currently uninsured, the employer mandate will enhance the ability of many women who are dependent on welfare and receive health coverage through Medicaid to leave welfare for paid employment. The absence of an employer mandate today serves as a disincentive to getting a job and going off welfare. Often, welfare recipients lack the training and qualifications for the types of jobs that provide health benefits. As a result, they are forced to choose between taking a job without health insurance or continuing to rely on public assistance with the attendant health benefits. Just last week the Wall Street Journal cited a study showing that "welfare caseloads would drop 25% if private health insurance that matches the comprehensive coverage of Medicaid were extended to all working women who head households."⁶ An employer mandate would do just that.

While eliminating one of the primary obstacles to getting off welfare by imposing an employer mandate, the Health Security Act also includes provisions to protect employers -- especially small employers with low-wage workers -- against overbearing health insurance expenses. The bill establishes percent-of-payroll caps, which vary depending on the number of employees and the average wages, to ensure that the cost of covering employees will not prove too onerous. For example, no employer would ever pay more than 7.9% of payroll toward employee premium contributions. Total premium liability is capped at 3.5% of payroll for employers with less than 25 employees and average annual wages up to \$12,000.

II. Recent Experience with Family and Medical Leave

As this Committee debates the issue of the impact on employers of an employer mandate, we urge you to look at the experience that we are having with one of the newest employer mandates: family and medical leave. This federal policy, enacted by Congress a year ago, almost to the day, requires businesses with more than 50 employees, and the federal government, to provide up to twelve weeks of unpaid leave to workers with an urgent family need: the birth or adoption of a child; the serious illness of a child, parent or spouse; or in the event of the worker's own serious illness. Although the federal law has not been in effect long enough to provide any reliable data about its impact on business, state family and medical leave requirements that have been in effect over the last several years, as well as studies of businesses providing this benefit, yield positive and encouraging information about its impact on employers.

Experience from the states and from the business community itself demonstrates that the requirement to provide this benefit does not have an adverse effect on business as many employers had claimed. A survey of four states with mandatory family leave requirements -- Minnesota, Oregon, Rhode Island and Wisconsin -- found that a sizeable majority of employers did not incur increased costs: 71% reported no increase in training costs, 81% reported no increase in costs related to unemployment insurance and 55% reported no increase in administrative costs. When we remember that one of the most oft heard objections to a mandatory policy was increased costs, these findings are very significant.

Moreover, contrary to employers' expectations, there is no negative impact on the business climate in states where employers are required to provide family leave. A 1988 study by the National Association for Working Women comparing business activity in states with and without required leave policies found that there was no negative correlation between growth in the small business community and required leave. Indeed, small business in states with mandated leave grew at a rate 21% greater than small business in states without such a

⁶ Birnbaum, Jeffrey H. and Frisby, Michael K., "Clinton Pledges that Crime and Welfare Issues will get Near-Equal Billing with Health Care," Wall Street Journal, January 26, 1994.

requirement. Finally, of course, numerous companies, such as Aetna, that provide family leave reported that, contrary to the rhetoric from many in the business community, offering this benefit saved money, as worker hiring and re-training costs were averted.

In short, what we have learned from our experience with family leave is that many of the claims of imminent disaster are simply not valid and that adjusting to an employer mandate is feasible and not as costly as the business community anticipated.

* * * * *

Mr. Chairman, in conclusion, federally mandated employer contributions to employee health insurance premiums would provide health security to so many Americans, particularly women, who are suffering from the health care crisis in this country. An employer mandate would guarantee coverage to the millions of women working for low wages, those working in the retail trade and service industries, and those who are employed part-time who currently do not benefit from any employer contribution whatsoever. The employer mandate detailed in the Health Security Act would also provide protection for women who are unemployed and who rely on a working spouse for coverage, as well as make paid employment a viable alternative for women on welfare.

Despite dire predictions from opponents of health care reform, recent experience with family and medical leave laws indicates that employer-mandated contributions to health insurance premiums will not have an overall adverse effect on business. The great number of businesses already providing health insurance will benefit. Small businesses where the owner must find coverage at inflated costs will benefit. And those not now paying for any coverage at all will not only be doing their fair share, but will find a workforce with fewer incentives to leave because of the gap.

History teaches us that opponents of reform often claim that changing the status quo will lead to disaster. In 1935, for example, when Congress was debating whether or not to enact Social Security legislation, pundits claimed that "imposing directly upon industry such a tremendous burden . . . is bound to cause a reaction which will result in prolonging the depression indefinitely."⁷ Of course, the Social Security Act was passed despite such protestations, and has proved to be one of the great pieces of social legislation in this century. You in this Congress have the opportunity to make your mark in history by passing another great piece of legislation that will provide health security to most Americans. We urge you not to be taken in by arguments that the employer mandate will impose an expense that businesses cannot afford. These arguments are no truer today than they were in the Social Security context almost 60 years ago.

⁷ Congressional Record, April 12, 1935, p. 5544 (House) (Statement of Representative Knutson of Minnesota).

**STATEMENT OF GWEN M. VAN VLECK, DIRECTOR OF
GOVERNMENT AFFAIRS, ESCROW INSTITUTE OF CALIFORNIA**

Ms. JACOBS. Ms. Van Vleck.

Ms. VAN VLECK. Thank you, I am Gwen Van Vleck, director of government affairs for the Escrow Institute of California. This is an association of small businesses, mostly owned and operated by women.

Most of our concerns have been adequately addressed today, so I would limit my comments to the manner of premium payments when two or more workers of the same family are employed by different employers. We see a need for very clear guidelines to eliminate the possibility of duplicate rather than shared payment.

The bill is clear in section 1011 that all workers of the same family must belong to the same plan, and that issue is not debated. However, the omission of clear bill language regarding how premiums of the plan are to be paid could result in duplicate payment without increased coverage, resulting in no benefit to anyone but the insurance company.

For example, one of the reasons many small businesses are not able to provide insurance coverage to their employees today is because insurance companies refuse to provide a plan unless all eligible employees are enrolled in the plan regardless of whether or not they are already insured under a spouse's policy.

The Health Security Act with the proworker's standard could, if not careful, perpetuate this inequitable practice. The bill or the accompanying House report should provide special rules, not only for the two-worker families, but multiple-worker families in order to include working dependent children and part-time jobs.

The act should consider how payment will be handled if one family member works full-time and has an additional part-time job with another employer. It should also provide guidance for payment of the cost if one family member works full-time and one or more members work part-time, or if all members work part-time.

The act must also include how the balance of the premium, which is attributable to the employee, will be handled among the working family members. There could be duplication there. The summary of the bill suggests that payment shall be based on a per worker standard and allocated among all the employers.

We believe this will be an oppressive and unnecessary administrative burden. Instead, we believe families should be allowed to designate who is the primary worker in the family.

We appreciate the extent to which the plan considers and seeks to protect small businesses, however, to impose employer payment of health care premiums is an unfair burden and we are opposed to the mandates. Instead, we support the consumer mandate with direct assistance.

If, however, in the final bill the premium is to be a shared employer expense, the impact on small businesses can be significantly reduced by issuing carefully constructed guidelines for the multiworker family.

In the interest of reaching a compromise on this difficult issue, we suggest implementing an allocation of cost based on a sliding scale. The disproportionate financial burden to small businesses

could, and should, be considerably reduced by assessing a percentage of the fee based on the overall size of the employers involved.

We urge you to seriously consider the effect these proposed employer mandates based on a "per worker" standard will have on the small independent businesses that are so necessary to our economy.

We thank the committee for the opportunity to provide our views on this issue.

Mr. JACOBS. Time to move on to this gentleman.

[The prepared statement follows:]

**STATEMENT OF GWEN M. VAN VLECK, C.S.E.O.
DIRECTOR OF GOVERNMENT AFFAIRS
ESCROW INSTITUTE OF CALIFORNIA**

Mr. Chairman and Members of the Committee, I am Gwen Van Vleck, Director of Government Affairs for the Escrow Institute of California (EIC).

EIC appreciates the opportunity to appear before you today to testify with respect to the Employer Mandate Provisions of the Health Securities Act (H.R. 3600). EIC is concerned with the provisions of The Act governing the administrative aspects of premium payments when two or more workers of the same family are employed by different employers.

Our concerns are two-fold. First, clear guidelines must be established for the manner of insurance payment when two or more members of the same family are employed to eliminate the possibility of a duplicate payment. Second, we believe that the "per worker" standard for allocations of premiums would be an extreme financial and administrative burden on small businesses.

Issue No. 1: Clarification of premium payment in Two-worker Family.

The bill is clear in Section 1011 that all workers in the same family must belong to the same applicable plan; that issue is not debated. We agree that the family should be permitted to choose which of the employer-offered plans provides the insurance coverage that best meets the needs of the family. We are pleased that the bill provides for this choice.

However, the omission of language regarding how premiums on the applicable plan are to be paid could result in duplicate payments without increased coverage, resulting in no benefit to anyone but the insurance company.

For example, many small businesses are not able to provide insurance coverage to their employees because insurance companies refuse to provide a plan unless all eligible employees are enrolled in the plan, regardless of whether they are already insured under a spouse's policy. The Health Security Act, by neglecting to include direction and guidance in the payment of policy premiums, could perpetuate this inequitable practice.

Explicit Bill language must make clear how payment of the premium is to be handled so that it does not result in a duplicate payment without increased benefits to the insured.

The Escrow Institute of California (EIC) is a non profit trade association representing an industry of more than 750 licensed escrow companies, and their affiliates. Most of these firms are owned and operated by women, and all are small businesses employing 7,500 active and 2,700 inactive practitioners. These licensed practitioners are responsible for over 400,000 real estate closings annually. In good economic times the value of these transactions is estimated to exceed 20 billion dollars a year. The organization is devoted to providing independent, neutral escrow closing services for the benefit of the public in real estate and business opportunity conveyances.

The Bill or accompanying House Report should provide special rules, not only for two-worker families, but for multiple-worker families in order to include working dependent children. The Act should consider how payment will be handled if one family member works full time and has an additional part time job with another employer. It should also provide guidance for payment of the cost if one family member works full time and one or more members work part time, or if all family members work part time.

The Act must also include how the balance of the premium which is attributable to the employee will be handled among the working family members.

Issue No. 2: Designation of Primary Insurer

EIC appreciates the extent to which The Plan considers and seeks to protect small businesses. However, to impose employer payment of health care premiums on small businesses is an unfair burden and our association is adamantly opposed to such mandates.

If mandates to employers become a reality under this or any other plan, the impact on small businesses will be tremendous. Many employers will not be able to survive this additional financial burden. This burden to small businesses must be relieved wherever possible. EIC believes this impact can be significantly reduced by issuing carefully constructed guidelines for the multi-worker family.

The summary of the bill suggests that payment shall be based on a "per worker" standard and allocated among all the employers. We believe this will be an oppressive and unnecessary administrative burden. Instead, the family should be allowed to designate who is the primary worker in that family. That employer should bear the burden of the insurance premium. It should be sufficient for the other working members of the family to show evidence of coverage to the secondary employers.

If, in the final Bill, the premium is to be a shared employer expense, in the interest of reaching a compromise on this difficult issue, we propose implementing an allocation of cost based on a sliding scale. The disproportionate financial burden to small businesses could, and should, be considerably reduced by assessing a percentage of the fee based on the overall size of the employer.

We thank the Committee for the opportunity to provide our views on this issue. We urge you to seriously consider the effect these proposed employer mandates will have on the small independent businesses that are so necessary to our economy.

STATEMENT OF BENNIE L. THAYER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NATIONAL ASSOCIATION FOR THE SELF-EMPLOYED

Mr. JACOBS. Mr. Thayer.

Mr. THAYER. Mr. Jacobs, contrary to what might be represented here today, I have not undergone a sex change, and I wish to state that up front.

Members of the committee, thank you for inviting me to be here today. My name is Bennie L. Thayer, and I am president and CEO of the National Association for the Self-Employed. We are the Nation's largest organization devoted primarily to the concerns of the self-employed and one of the Nation's largest organizations representing small business.

The NASE's more than 300,000 members live in every congressional district in the United States and engage in a wide cross-section of economic activities. We have backed health care reform for more than 3 years, and we have worked with the administration and Congress on many aspects of the problem.

We disagree, however, on whether employer-mandated health insurance would help solve America's health care problems.

Advocates of employer-mandated health insurance describe it as a way to achieve universal health care coverage, reduce the cost burden on the average worker, and better manage health care costs overall. The problem is these supposed advantages don't hold up under close analysis.

Universal coverage, for instance. Hawaii has had an employer-mandated coverage for many years, but it still has more than 8 percent uninsured. Even Canada's extensive mandates still leave 2 percent or more uninsured. Some say we can get universal coverage with more onerous mandates.

They call for reclassifying independent contractors as employees, thereby raising a major and unnecessary distraction of tax policy into the health care debate. They call for employers to cover part-time and seasonal workers. They call for harsher fines and penalties.

People making these demands do not know or are not acknowledging a basic economic truth: There really is no such thing as an employer mandate if we mean getting employers to pay for some economic benefit so that employees will not have to.

Our surveys in the NASE indicate that the microbusinesses we represent, those with five or fewer employees, will overwhelmingly respond to this mandate by cutting wages, salaries, laying off people, and even closing their doors despite the subsidies the administration proposes. Larger businesses will mostly cut salaries and other benefits.

The Treasury Department's own analysis, Mr. Jacobs, says this and I quote, "Wages and salaries would appear to fall by almost the full amount of an increase in employer contributions for health insurance."

So let's be honest. This mandate is not really going to help out any workers financially.

Let us look at controlling costs. Employer mandates will not control cost if they conceal true health care costs from most people and perpetrate the myth that health care is virtually a free good.

In conclusion, we look forward to working with this committee and the administration to shape lasting health care reforms, reforms that use individual responsibility and candor about cost to achieve health care goals rather than those that have been posited here.

Mr. JACOBS. Thank you, sir.

[The prepared statement and attachment follow:]

STATEMENT OF BENNIE L. THAYER
PRESIDENT AND CEO
NATIONAL ASSOCIATION FOR THE SELF-EMPLOYED

Chairman Rostenkowski, members of the Committee, thank you for inviting me to appear here today. I am Bennie L. Thayer, President and CEO of the National Association for the Self-Employed, the nation's largest organization devoted primarily to the concerns of the self-employed. The NASE's more than 300,000 members live in every Congressional District in the United States and engage in a wide cross-section of economic activities.

The NASE has backed health care reform for more than three years, and we are pleased to see the seriousness with which the President and Congress are dealing with the issue. We have had the privilege of working with Mrs. Clinton, Mr. Magaziner, and others in the Administration, and we support the goals for health care reform that the President outlined in his address to Congress last fall.

Today, however, we must focus on an area where we have some honest disagreements with the Administration's Health Security Act and other, similar pending legislation -- the issue of employer-mandated health insurance. Would a requirement that employers pay 80% of the cost of their employees' -- and employee dependents' -- health insurance help solve America's health care problems?

The NASE doubts it. Let me explain why.

Advocates of employer mandated health insurance describe it as a way to:

- achieve universal health care coverage
- avoid having the average worker carry too much of the cost of this universal coverage and
- better manage health care costs overall.

The problem is, none of these supposed advantages holds up under close analysis.

First, would employer mandates get us to universal coverage? If "universal" means that every single person is covered, probably not. A careful recent study of Hawaii, where employer-mandated health insurance has been in effect for 19 years, noted:

The consistent pattern that emerges from careful consideration of available data is that the Hawaiian mandate did relatively little in extending insurance to the uninsured. While Hawaii does have high rates of coverage compared to other

states, this is due largely to the characteristics of Hawaii's population.¹

Indeed, even the most optimistic assessment of Hawaii's "universality" puts the number of uninsured at 3.9% of the total population. Other estimates range to 8% and higher.²

The same is true of Canada, where "universal coverage" has been mandated for over 25 years, and where a persistent 2-3% or more of the population reportedly remains uninsured.

So what's the solution? Some say the solution is to simply make the mandates more onerous. Include part-time and seasonal workers, capture independent contractors by reclassifying them as employees,³ make the fines and penalties harsher.

That goes back to the second big misconception about employer mandates -- the idea that they take the burden off workers. The truth is, there is no such thing as an employer mandate -- if we mean requiring employers to pay for some employment benefit so that the employees won't have to. An employer facing mandated employee costs is in effect facing a payroll tax. As with any such tax, the employer has four choices: increase prices to customers, cut profits, reduce wages and benefits, or shut down the business.

What would very small businesses and the self-employed do? Cutting profits isn't much of an option with the razor-thin profit margins typical of microbusinesses. Nor is increasing prices, in most cases. Wages are typically low to begin with. So we had an independent polling firm to ask a cross-section of the very small businesses that NASE represents what *they'd* do in the face of such a mandate. Here's what the survey turned up.

This is a universe in which over 85% of the businesses have fewer than 5 employees. 61% of these businesses reported gross business revenue of less than \$100,000 annually. An identical 61% reported payrolls averaging less than \$24,000. *Of the 43% who have employees, one fourth said they would be forced to close their doors if employer-provided health insurance were mandated. Another 29% said such a mandate would require them to lay off people. Slightly fewer, 24%, said they could avoid layoffs, but would sustain a*

¹ Andrew W. Dick, "Will Employer Mandates Really Work? Another Look at Hawaii", *Health Affairs*, Vol. 13, #1, Spring, 1994, p. 343.

² The Employee Benefit Research Institute puts Hawaii's 1992 figure at 8.1%. See *Sources of Health Insurance and Characteristics of the Uninsured*, EBRI Issue Brief Number 145, January, 1994, Table 3, p.14.

³ The NASE will have more extensive testimony on the reclassification of independent contractors when it testifies before the Select Revenue Measures Subcommittee of this Committee February 9. For now, we would note that the definition and tax law status of independent contractors, which has been an immensely complex tax issue for at least 15 years, is far too complicated to be treated as a sidelight to health care reform. Attempting to do so will prove to be a major and unnecessary distraction for this Committee and Congress.

"significant" impact on wages and profitability. Only 17% said a mandate would have little or no effect on them.⁴ In short, this mandate would disfigure and destroy microbusinesses like a sharp sword.

So who would really pay? Would employees really be avoiding health care costs?

The fact that employees would actually bear the brunt of any employer mandate is not exactly news to most economists. The basic point has been made as recently as last month by analysts as philosophically diverse as the Heritage Foundation's Stuart Butler and Stanford University's Victor Fuchs.⁵ The Treasury Department's own analysis of the Health Security Act notes:

Based on observable relationships within the NIA [National Income Accounts], *wages and salaries would appear to fall by almost the full amount of an increase in employer contributions for health insurance.*⁶

Is there some compelling policy reason to have employers manage everybody's health care? On the historical evidence, no. The origins of the employer-based health insurance system -- as an evasion of World War II wage controls -- are by now so well known that they do not bear repeating. So too is the inequitable tax treatment of employer contributions to health insurance which has permitted this anomaly to flourish.

Rather than directly address the inefficiencies and inequities this strange system has wrought over time, "employer mandate" legislation, including the proposed Health Security Act and other measures, would magnify those inefficiencies and inequities. The HSA's elaborate subsidies, regulations, controls and governing bodies would burden employers with complexity and added costs, to be sure. Many of the people we represent would be especially hard hit, as I just noted. But the overall effect of the plan would be to *take away* whatever

⁴ This survey was presented in its entirety to this Committee in our November 19, 1993 testimony.

⁵ Butler: "[A]lthough a family might be 'better off' in terms of health spending under the Clinton plan, the extra cost borne by the employer may lead to a reduction in the wages paid to the family of more than the family's health savings. Or the worker may receive a pink slip. Economists generally assume that about 88 percent of the cost of an employer mandate is recovered by the employer reducing the wages." *What the Lewin-VHI Analysis of the Clinton Health Plan Really Shows*, Heritage Foundation F.Y.I., January 7, 1994, p. 3.

Fuchs: "It is a commonplace in the current debate to assume that health insurance is now paid for by employers. Nothing could be further from the truth. . . One thing is certain: [my employer] does not pay for my health insurance in any meaningful sense.... Most policy analysts know that employers do not really bear the cost of health insurance. But some of them regard it as a useful myth for selling universal coverage to an unwilling and unsuspecting public." "The Clinton Plan: A Researcher Examines Reform", *Health Affairs*, Vol. 13, No. 1, Spring 1994, p. 102-3.

⁶ *Estimating the Impact of Health Reform on Federal Receipts*, Memorandum, Office of Tax Analysis, Treasury Department, December 9, 1993. Emphasis added.

health insurance policies those employers have previously provided, and to basically require employees to purchase *new* policies based on government specifications. Though employers would pay whatever part of their 80% they could not pass on, they are really bystanders. All purchasing activity would be funnelled through government bodies, and all other major health care-related decisions would be made by other government entities. In reality, this would bring about a system of *individual* mandates paid for by most, but not all, employers⁷ and then cross-subsidized by government using assorted taxes and general revenues.

The obvious question is "why do it this way?". Why add vast complexity to employer-based health insurance to end up with an individual mandate system? Why not simply start over with a financing structure based on individual responsibility for health care? Why not eliminate all the costly back channels of subsidies, regulations, controls and governing bodies required to maintain the fiction that the system is being paid for by employers?

The only "advantage" to an "employer mandate" method of financing is a political one, and so far it has been largely unspoken. It is concealment. The "employer mandate" charade largely conceals health care costs from most employees, which is to say most people. Aggregate health care costs are also concealed. Although the federal government would be stipulating in amazing detail what the health care the system would be expected to deliver, the whole operation would be "off budget" since employers would be paying a so-called "premium" to so-called "alliances" set up by the government. Thus, the costs of the federal government's decisions would be concealed outside the federal budget. Translated, that means the costs would be concealed from the taxpayers.

Concealment of facts the voters have a right to know is a very bad government policy for at least two reasons. First, it further erodes trust in government. The nation experienced epic political concealments in the Vietnam and Watergate eras. The costs of many entitlement programs have been concealed until they exploded. Federal budgets of the early '80's were designed to conceal the huge federal deficits of those years. The magnitude of the S&L crisis was initially concealed. So were assorted scandals emanating from the White House and Congress. The costs of this legacy of concealment can be seen in the vastly reduced respect Americans have for their government and in the spectacular growth in the popularity of candidates and movements that give voice to antigovernment passion.

We cannot solve America's health care problems by attempting to camouflage the scope and costs of what we are proposing. The voters *will* notice, and it will lead to a terrible backlash, because health care affects each and every one of them personally. The health care solution is not more concealment.

Concealment is also a bad policy for economic reasons. As long as Americans are

⁷ It is not clear whether and to what extent companies employing more than 5,000 workers would participate in this system and how public-sector employees would fit into it.

encouraged to live in a dream world in which health care is seen as a free, or nearly free, good -- paid for with someone else's money -- health care costs will never be brought under control. All the paraphernalia of "top down" control --draconian controls on health care utilization, global budgets, price controls, and other schemes of regulation and control -- may tighten the lid on the pressure cooker, but the steam inside will continue to build up.

As long as "bottom up" demand continues to build unabated in the pressure cooker, supply restrictions will have to become more and more complex and detailed. For the slightest crack or loophole in the system can permit tremendous quantities of pent-up "steam" to escape. Last Monday, the Washington Post showed how a small provision in the Medicaid program, estimated to cost \$95 million over 3 years, exploded into a \$10.8 billion subsidy in a single year through an accounting loophole.⁸

No piece of legislation, however lengthy, can anticipate every such eventuality. Indeed, the more complex the legislation, the more likely it is to inadvertently open up such loopholes or to encourage inventive attorneys to try. The cost pressure will continue to increase as long as individuals have little or no incentive to control costs on their own.

This is not simply "Washington insider" wisdom. Earlier this week, the NASE conducted another poll of its members, this time on the issue of cost control. We offered a sample of 623 self-employed people a choice of five strategies for health care cost control. Two of these strategies were "bottom up" approaches, based more on individual financial responsibility -- higher insurance rates for smokers and drug users, and medical IRA's. As the attached polling results show, those options were favored by majorities of 72% and 74%, respectively. Three "top down" approaches to cost control, without the individual responsibility component -- limiting choices of providers, federal price controls and global budgets -- were disapproved by majorities of 86%, 74%, and 78%, respectively.

If there is one clear inference from these numbers, it is this: *the people want to be trusted with these cost control decisions themselves.* And that is what Congress should do.

For these reasons, the NASE has favored health care reform legislation which surfaces the true costs of health care and requires individuals to bear a fair share of those costs themselves. We advocate greater transparency, not more opaqueness. Turning today's highly flawed system of employer-provided health insurance into an even more disfigured "mandate" would be exactly the wrong way to go.

Today's hearing, of course, is a very early stage in what will be a long, intensive process. We look forward to further work, based on a shared commitment to genuine reform, with the White House and Congress in the weeks ahead.

⁸ Dan Morgan, "Small Provision Turns Into A Golden Goose", *Washington Post*, January 31, 1994, pp. A-1, 8. Ironically, public sector catastrophes like this are sometimes used as rationales for further restrictions on the private sector, such as new price controls on providers.

NASE HEALTH CARE POLL

Results for: NASE Legislative Action Network Survey

Call dates: January 31, 1994 - February 1, 1994

Dials: 2362 Contacts: 765 Completed Surveys: 623

Question: Did you watch the President's State of the Union Address?

Results: Yes 301
 No 322

Question: Which one of the following policy issues do you believe is most important for the President and Congress to focus on during 1994?

Results:	A) Crime	133	21%
	B) Welfare Reform	91	15%
	C) Job Creation	69	11%
	D) Job Training and Education	46	7%
	E) Health Care Reform	119	19%
	F) Reducing the Federal Deficit	165	27%

Question: How satisfied are you personally with the health care you receive today?

Results:	A) Very Satisfied	217	35%
	B) Fairly Satisfied	245	39%
	C) Somewhat Satisfied	84	14%
	D) Not Satisfied at all	77	12%

Question: Which of the following statements are closest to what you think about health care reform?

Results:	A) Our health care system is broken and we need to overhaul the entire system.	136	22%
	B) Overall, our health care system works, but we need to make some changes to fix what is not working.	423	68%
	C) There is no health care crisis, and we do not need to make any significant changes in the health care system.	64	10%

Question: Under the Clinton Health Care Plan, a national board would determine the minimum level of benefits to be included in the health insurance policy every American purchases. Which of the following statements do you favor?

- | | | |
|---|-----|-----|
| A) One policy, with identical standard benefits, for every American | 72 | 12% |
| B) Individuals could choose from a variety of plans with different benefits | 551 | 88% |

Question: We should control costs by requiring people who choose to continue unhealthy habits like smoking and using drugs to pay more.

- | | | |
|--------------|-----|-----|
| A) Agree | 449 | 72% |
| B) Disagree | 116 | 19% |
| C) Undecided | 58 | 9% |

Question: We should control costs by limiting the patient's choice of physicians.

- | | | |
|--------------------------|-----|-----|
| Results: A) Agree | 56 | 9% |
| B) Disagree | 536 | 86% |
| C) Undecided | 29 | 5% |

Question: We should control costs by allowing individuals to set aside some money, tax-free, to pay for medical expenses, like we do with individual retirement accounts, and whatever is left over in the account after paying medical bills, the person would be permitted to keep.

- | | | |
|--------------------------|-----|-----|
| Results: A) Agree | 464 | 74% |
| B) Disagree | 92 | 15% |
| C) Undecided | 67 | 11% |

Question: We should control costs by letting the federal government set health care prices.

- | | | |
|--------------------------|-----|-----|
| Results: A) Agree | 89 | 14% |
| B) Disagree | 467 | 75% |
| C) Undecided | 67 | 11% |

Question: We should control costs by having the federal government set a national limit on how much money in the country can spend on health care every year.

- | | | |
|--------------------------|-----|-----|
| Results: A) Agree | 78 | 12% |
| B) Disagree | 490 | 79% |
| C) Undecided | 55 | 9% |

STATEMENT OF HELAINE LEVY, PRESIDENT, OLD TUCSON STUDIO, TUCSON, ARIZ., ON BEHALF OF ADVOCATES FOR FLEXIBLE EMPLOYMENT

Mr. JACOBS. Ms. Levy.

Ms. LEVY. My name is Helaine Levy. I am president of Old Tucson Studios in Tucson, Ariz., a year-round Old West theme park and movie location. Each year approximately half a million guests visit our park.

I am here today on behalf of Advocates for Flexible Employment, a coalition of employers and trade associations providing a voice for part-time, seasonal and temporary employment, and the millions of Americans who choose such work arrangements.

AFE recognizes the need to reform our health care system, but an employer mandate would restrict the ability of many AFE members to provide job opportunities. If an employer mandate is enacted, Old Tucson's labor costs would increase significantly because we are such a labor-intensive operation; even a capped mandate would force us to reduce our non full-time staff significantly.

At Old Tucson Studios we have used part-time and seasonal employees very effectively to supplement our full-time staff of 75. All together, old Tucson employs approximately 350 people. Our full-time staff are mostly office employees, and we hire another 275 people on a part-time or seasonal basis simply to make the park run.

Yet because of high turnover, we actually process more than 600 employees a year. Many of these people are students, retired people, individuals, and parents who want flexible job opportunities.

If we hired mainly full-time employees, the flexible work schedules we offer would be reduced dramatically. This would mean that we would be unable to provide responsive service to our customers, and that job opportunities for 275 of our current employees could disappear.

The cost of an employer mandate will inevitably lead to increased admission and concession prices; yet at the same time we would be reducing our work force and thereby undermining our ability to provide the best possible product to our customers.

Because the demand for our product, entertainment, relies on discretionary income, our customer demand is highly elastic. The entertainment offered by the amusement park industry is people-intensive. Our employees, whether full-time, part-time, temporary, or seasonal, make our businesses succeed.

The same is true for all industries that provide flexible job opportunities; retailers and restaurants, the hospitality industry in general, construction, and even the health care industry.

The businesses of AFE members respond to the demands of their customers. We cannot do that only with full-time employees, nor can we do it with dramatic increases in our per employee cost.

We urge you to review carefully the impact which an employer mandate will have on your individual constituents and on their employers and employees who choose or need flexible work arrangements.

Thank you.

Mr. JACOBS. Thank you, Miss Levy.

[The prepared statement and attachment follow:]

**STATEMENT OF HELAINE LEVY
PRESIDENT
OLD TUCSON STUDIOS**

Good afternoon, my name is Helaine Levy and I am President of Old Tucson Studios located in Tucson, Arizona. I am here today on behalf of Advocates for Flexible Employment (AFE). My company is a year-round Old West Theme Park and movie location. Each year approximately 500,000 guests visit our park, with winter as our peak season.

Advocates for Flexible Employment is a coalition of employers and trade associations which provides a voice for part-time, seasonal and temporary employment and the millions of American workers who choose such work arrangements. The employers involved, such as myself, have traditionally offered these opportunities because they fit into our peak time of day or year requirements to meet the demands of the public we serve.

AFE recognizes the need to reform our health care system. Many Americans do not have health insurance or access to basic health care because they cannot afford either. AFE believes health insurance should be universally accessible on a non-discriminatory basis. However, a mandated, employer-subsidized health insurance program would restrict the ability of many AFE members to provide job opportunities in America's fastest growing job sector, and would cause us to reduce the number of employees we hire.

We at Old Tucson Studios have effectively used part-time and seasonal employees to supplement our full time staff of seventy-five people. Because of fluctuating seasonal demand, as well as increased patronage on weekends and special promotions, we have found it very productive as well as mutually beneficial to hire approximately 250 part-time and seasonal workers a year.

According to the Bureau of Labor Statistics, over 70% of the nearly 20 million Americans who worked part-time in 1992 did so by choice. Our experience at Old Tucson Studios follows that pattern. Most of the people we hire on a part-time or seasonal basis would not be able to work full-time or year-round. Teenagers, undergraduates, and post-graduates trying to earn a little extra spending money or working their way through school would have to stop if we required them to work full time or year round. Spouses who work for us on weekends when our traffic is much higher, or during vacation periods, or for that matter during the week, would have to forego supplementing their family income if we were to curtail or discontinue flexible work arrangements. Similarly, the flexible work opportunities we provide to seniors who find it hard to make ends meet on their retirement income, or who simply enjoy contact with the public, would be significantly reduced if Old Tucson became solely a full time employer.

Yet that is precisely what we believe an employer mandate will force us to do. Because we are such a labor intensive operation, especially during peak times of the year, an employer mandate, even one capped at 7.9% of payroll, would force us to reduce our part-time and seasonal staff. We would be forced to automate where possible and hire full time but fewer employees. This would mean not only that we would be unable to provide responsive service to our customers, but also that our costs would jump considerably.

Such increases would result in our having to raise our admission and concession prices. Our business relies on the availability of discretionary income; therefore, demand for our product -- entertainment -- is highly elastic. The entertainment offered by the amusement park industry is people intensive. Our employees make our business succeed.

Old Tucson Studios falls in the huge gap in which no discounts are available under the Clinton Plan. We must enroll in the regional alliances because we are not small enough to qualify for subsidies and we are not big enough to form a corporate alliance. Many AFE members are multi-state employers of over 5,000 employees who wish to keep their current insurance plans. These companies, nationally-known chain restaurants and retailers, believe that the Clinton plan poses even greater barriers to hiring part-time and seasonal employees. For them, the mandate requires the 80% employer contribution on a pro-rata basis, with the 7.9% cap not being applicable. For such employers, part-time and seasonal employees would not even be enrolled in their plan but instead would automatically be covered by the regional

alliance.

Consider the case of a part-time or seasonal employee working at a company which elects to form a corporate alliance. Since the 7.9% cap does not apply for an employee who works less than 30 hours a week at \$5.00 an hour, the additional cost to the employer per hour (using the Clinton estimates in "Health Security, The President's Report to the American People") translates into \$1.59 for employees with children -- or a 32% increase in payroll. For the single individual earning the same \$5.00 an hour, the incremental cost of providing health insurance would be approximately \$1.00 per hour or a 20% increase in payroll.

Such disproportionately high increases in the cost of hiring these employees cannot be absorbed because of the labor intensive nature of our businesses. Consider also another factor unique to AFE members. Even though Old Tucson Studios employs around 350 people during peak periods, we actually process about 800 employees every year. Thus, the high increases in employee costs would be exacerbated by the high turnover which our people - intensive businesses experience.

Basically, if the Clinton plan is adopted you will not only be imposing severe financial burdens on labor intensive companies, many of whom operate on slim profit margins, but you will also have government conferring a distinct competitive advantage to some businesses. This is not a result that we in AFE can support, nor one we believe Congress would endorse.

We strongly urge you to review carefully the impact that an employer mandate will have on your constituents who choose or need flexible work arrangements and those employers who currently provide them.

In closing, I would like to note that my industry's trade association, The International Association of Amusement Parks and Attractions is currently surveying its members to determine the impact of the Clinton Health Reform Plan. We would be happy to share the results of that survey with the Committee as soon as it is available.



EXPANDING JOB OPTIONS AND OPPORTUNITIES FOR ALL AMERICANS

ADVOCATES FOR FLEXIBLE EMPLOYMENT: A POSITION PAPER ON HEALTH REFORM

Advocates for Flexible Employment (AFE) is a coalition dedicated to providing a voice for part-time, seasonal and temporary employment and the millions of American workers who choose to benefit from flexible employment. Our membership represents a variety of industries -- ranging from retail to restaurants to amusement parks and technical and clerical office assistance -- that collectively employ millions of Americans in part-time, seasonal and temporary work.

AFE and Health Care Reform

AFE recognizes the need to reform the U.S. health system. Many Americans do not have health insurance or access to basic health care because they cannot afford either. AFE believes health insurance should be universally accessible on a non-discriminatory basis.

However, a government mandated employer-subsidized health insurance program would have a severe impact on the ability of most AFE members to continue to provide job opportunities in America's fastest growing job sector.

The Benefits of Flexible Employment

- More than 20 million Americans demand part-time, seasonal or temporary jobs because it suits their lifestyle. For example, parents wanting to be home when their children return from school; a student needing to pay for school or a car; or an author needing to feed her family while she searches for a publisher for her first book. These part-time, seasonal and temporary employees appreciate the flexibility associated with their job choice.
- Flexible employment is not only beneficial to the employee. Many industries, by their very nature, utilize part-time, seasonal and temporary employees because traditional full-time jobs simply do not respond to industry needs. Labor-intensive and consumer-sensitive industries cater their production and service provision to the peak time of day and peak time of year demands of their customers.
- Moreover, the nature of the part-time, temporary and seasonal work force is different from that of the traditional full-time workforce. Training costs to industries which utilize flexible employment can be disproportionately high because of high turnover rates. Many part-time, temporary and seasonal positions give determined Americans their first-time work experience.
- Introductory, or in many cases transitional work opportunities, offer Americans entree to numerous career paths. Many AFE member companies offer a variety of career-oriented positions and have a tradition of promoting from within.
- All these characteristics make the cost of finding, hiring, training and keeping quality employees difficult and expensive for AFE member companies.



EXPANDING JOB OPTIONS AND OPPORTUNITIES FOR ALL AMERICANS

**Advocates for Flexible Employment:
Expanding Job Options & Opportunities for All Americans**

Flexible employment: meeting the needs of a changing workforce

Although more than 20 million Americans choose part-time, seasonal or temporary employment, this booming job sector is sometimes misunderstood by lawmakers and the media. That's why the Advocates for Flexible Employment, a national coalition, is dedicated to providing a voice for the millions of part-time, seasonal and temporary employees and their families who count on flexible work schedules to meet their lifestyle demands. In fact, as the American workplace continues to change, the millions of new workers holding part-time, seasonal and temporary jobs represent the fastest growing employment group in the nation, giving them a larger voice in the issues that directly affect their jobs and their futures.

Who are part-time, seasonal or temporary workers? They're senior citizens, working parents, students, professionals, government workers and anyone else who needs flexibility on the job and at home. They're students who need to earn money to pay for education but cannot commit to rigid schedules or inflexible hours. They're working parents who want to be home when their children return from school. They're retirees who want to stay active but not lose pension benefits by working full-time. They're professionals who want more control over their lives and schedules. They're men and women looking for training and new job opportunities. Above all, they're hardworking Americans who are making a real contribution to the nation's economy.

Flexible employment is important to the economy

According to the U.S. Bureau of Labor Statistics (BLS), over the past 20 years the number of part-time workers increased 88.9%, while full-time employment rose just 48.6% over the same period. And part-time jobs are just one type of flexible employment. The rate of growth is even greater when other forms of flexible employment - seasonal and temporary - are included. Flexible employment is providing new jobs to keep the American economy growing.

Flexible employment affords many advantages to employees and employers

Flexible employment offers employers and employees alike many advantages full-time jobs can't match. Employees appreciate the ease with which flexible employment helps them balance other responsibilities and interests.

For those exploring new careers, flexible employment provides a glimpse of particular areas of interest. Those unable to find full-time work in their chosen field can turn to part-time, seasonal and temporary opportunities for support while they search. And for many young Americans, flexible employment offers an introduction to the work force.

Employers also appreciate the productivity flexible employment provides when there is insufficient demand to add full-time workers, but short-term needs require extra help. Flexible employees also help a business broaden its commitment to customer service during peak hours or seasons. AFE member employers reach out to the employees other businesses often ignore - persons with disabilities, older Americans, students and young parents. AFE seeks to protect and enhance the mutual benefits flexible employees and their employers enjoy.

What employees like about the flexible work option

Here's what some flexible employees from around the country have to say about their jobs:

"I am able to work a part-time schedule that allows me to be home when my children go to and come home from school. I can earn money and still not sacrifice time away from my family."

"The flexible schedule at my job has allowed me to earn the money I need to get through college. My financial assistance has never been enough to pay for tuition, room and board. Without this money, I could never have made it."

"The flexible employment option allows me to maintain a full staff during the lunchtime rush. The customers are happy, the workers are happy and my business is growing."

"When I retired, I didn't want to stop working completely. This job helps me supplement my income and keeps me in the work place."

"I've almost completed my first novel. My part-time job has allowed me to earn money, while still having time to pursue my dreams as a writer."

"When my mother became ill, I was able to work part-time which allowed me time to care for her and put myself through graduate school in the evenings."

Flexible Employment Facts

In 1992, there were more than 20.4 million part-time workers in this country. (Employee Benefit Research Institute)

Since 1969, the U.S. part-time work force has grown an average of 2.8% annually. (Employee Benefit Research Institute)

A growing number of professionals are choosing to work part-time. In 1991, the number of part-time professionals rose to 4.1 million. (U.S. Bureau of Labor Statistics)

20% of part-time employees are retired workers supplementing their retirement income. (Association of Part-Time Professionals)

More than 60% of companies surveyed felt that part-time on-site work experience is the most important school-work linkage in addressing the labor and skill shortage in their industry. (National Association of Manufacturers)

70% of college students work during the academic year, most of them utilizing some form of flexible employment. (National Association of Student Employment Administrators)

Seasonal flexible employment provides a major source of jobs for one of the most difficult parts of the work force to place - summer youth.

80% of those workers choosing the temporary employment option do so to gain additional income, while approximately 75% utilize temporary employment to aid them in getting a full-time job, improve skills, or for flexibility. (National Association of Temporary Services)

Temporary help jobs account for about 1% of all non-agricultural jobs in this country. The temporary help industry provides flexible employment for approximately 1.6 million Americans on any given day. (National Association of Temporary Services)

The technical temporary services industry, which provides high skill, high wage technical personnel to American industry and government, employs more than 200,000 technical specialists annually. (National Technical Services Association)

One industry utilizing flexible employment, the discount retail sector, accounts for more than 20% of all new jobs created in this country since 1991. A New York Times article described the discount retail sector as "a new engine for job creation."

Mr. JACOBS. Mr. Santorum.

Mr. SANTORUM. Thank you, Mr. Chairman.

Miss Kolker, you testified that Hawaii has a 95 percent insured rate. Mr. Thayer said it was 92 percent. I come from the State of Pennsylvania. Pennsylvania has a 92 percent rate of insured. We do not have a universal system. We do not have any mandates.

We have basically a private market system operated in Pennsylvania, and we reach 92 percent insured.

In fact, a more recent study, I hear, is coming out that says it will be up to 94 percent insured without a mandate. Do you think 94 percent is pretty good coverage?

Ms. KOLKER. I think it is a very high rate. I think we would like to see those figures and see whether that includes part-time workers, seasonal workers, whether it includes people not in the work force, whether it includes dependents.

Are these figures from the State Department of Labor?

Mr. SANTORUM. Yes.

Ms. KOLKER. That is so.

Mr. SANTORUM. We have the fourth lowest rate of uninsureds in all the studies. That is pretty consistent over the past several years. We are below Hawaii and the other States that have, "universal systems." And we do it because we have insurance companies—we have a Blue Cross system that does not exclude people with preexisting conditions.

We have a whole lot of insurance reforms that have occurred in Pennsylvania, that keep people once they are insured in the insurance system.

I guess the point—

Ms. KOLKER. This includes dependents as well?

Mr. SANTORUM. Yes. It is using the same numbers that everybody else in every other State uses. I don't think anyone disputes that number in Pennsylvania, advocates on both sides affirm the 92 percent figure.

The question I have is does that not really show that a "private system" with insurance reforms and others can get to where a mandatory system can get without employer mandates, and get the kind of quality insurance coverage and choices that we want in the private market system without going to something that is as big government as what you folks are advocating?

Ms. KOLKER. You certainly have a standard that other States should aspire to. But I think what we found with family medical leave is that we needed to have a mandate, not because of those who were doing what they were supposed to be doing, but because so many others were not.

Mr. SANTORUM. Why should we mandate that Pennsylvania change its system to accomplish the same amount of coverage it has now on a system that allows for the flexibility it does?

Ms. KOLKER. There are so many other issues. It is not just coverage. There are lots of questions about the cost of coverage, is small business paying disproportionately more than larger business.

Mr. SANTORUM. Do you believe that we can solve the cost problem without having the individual participate in the medical system?

Ms. KOLKER. I'm sorry?

Mr. SANTORUM. Do you believe we can solve the cost of health care, reduce the cost of health care, without having the individual involved in cost containment?

Ms. KOLKER. I think everybody has to be involved in the cost containment. I think the wellness kinds of programs that were discussed earlier, for example, are very important in helping to reduce individual health costs.

Mr. SANTORUM. One real quick question to finish out the line. Are you supporting the Clinton plan? I assume you are.

Ms. KOLKER. Yes, like many other people, we believe the Clinton plan is not perfect, but that it is a very important step in the right direction. For instance, it addresses many of the multiple problems, not just universal coverage, but the cost escalation and other issues.

Mr. SANTORUM. My final question is—and I still have not heard a good answer on this one, but if you have one, I will be glad to listen—where do you see the role of the individual at controlling cost in the Clinton Plan?

Where does the individual come in at all? They get this free card, remember, never to be taken away. Everything is covered. Here it is. Where is the role of the individual at controlling costs? What is the incentive for the individual to control costs there?

Ms. KOLKER. Well, there are still substantial copays and deductibles. I think every time that you go to the doctor and part of that bill comes to you, you are being made aware that the cost is not completely underwritten.

Mr. SANTORUM. Thank you.

Mr. JACOBS. Mr. Hoagland will inquire.

Mr. HOAGLAND. Let me ask Ms. Kolker a question, Ann, if I might. Do you see a way of pulling a sufficient number of people into the system to at least achieve substantial results in the near term without having an employer or an individual mandate?

Ms. KOLKER. I think that we have been where we are for so long—unfortunately the trends now are that more people are losing insurance instead of gaining insurance that we have to go with a mandate. Even though the consciousness has been out there for the last few years that we have a crisis in coverage the crisis has gotten worse.

If I felt that the trend was going in the other direction, I might give a different answer. But unfortunately, what we are seeing each year is an increase rather than a decrease in the number of uninsured.

Mr. HOAGLAND. Under Congressman Cooper's proposal, he would propose drawing people into the system by paying the premiums directly for the poor or portions of the premiums for the near poor by making health insurance premiums 100 percent deductible for the self-employed; other ways of giving financial incentives for people to insure themselves.

If we could bring that 15 percent uninsured down to 6 or 7 percent uninsured by using incentives and avoid the negative effect an employer mandate would have on that 85 percent of the community that already has insurance, would that be satisfactory?

Ms. KOLKER. What I would answer is that the bulk of people now are already insured through an employer mandate. It seems to me that it makes the most practical sense to build on the system where the bulk of people are already covered.

It is not a perfect system, but the vast majority, I think, about 60 percent of the people are already covered through the employer system. And one of the many concerns I have about the Cooper approach is that it would unravel the employer system that we have. Although it is imperfect and has many people who fall through the cracks, it seems to me an individual mandate would further undercut the current employer-based system.

Mr. HOAGLAND. Miss Lichtman, do you have any thoughts with respect to this area?

Ms. LICHTMAN. Not anything that Ann Kolker has not already said.

If we were not dealing with a nation that was not already heavily dependent on an employer-based system, you could be very creative and think about whole hosts of ways of creating new models of universal coverage.

But the fact of the matter is, if you take this nation in early 1994, we have a nation that it is overwhelmingly dependent today on an employer-based model, and I think in an attempt to leave as much of the system in place as is, that the Health Security Act addresses this issue of universal coverage through an employer-based system, not because I think anybody is wedded to that particular model.

Mr. HOAGLAND. Thank you.

Mr. JACOBS. Mr. McCrery.

Mr. MCCRERY. No questions.

Mr. JACOBS. Mr. Neal.

Mr. NEAL. No questions.

Mr. JACOBS. The committee thanks the panel for your contribution and regrets that you had to stay so long.

The next panel please come forward and meet Mr. Hoagland.

Mr. HOAGLAND [presiding]. I would like to welcome our final panel and again apologize that the hearing has taken this long. Let me first, if I might, yield to Mr. Levin of Michigan for an introduction.

Mr. LEVIN. Well, just briefly, Mr. Chairman, I want to say a special hello to Mr. Hartwig, who we have had the chance back home to discuss issues with Kelly Services, and I am very pleased that the entire committee, those of us who could be here and those who will review this testimony in their own offices, will have the opportunity to hear from them as well as the other members of the panel.

So to all of you at this too late hour welcome and again thank you for your patience.

Mr. HOAGLAND. I would like to yield to Mr. Neal from Massachusetts.

Mr. NEAL. Thank you, Mr. Chairman. I want to acknowledge Frank Colaccino, who I believe is still one of my constituents, a friend since high school, and who had the good sense years ago to get out of politics and to get into business.

And I dare say he has never regretted that decision for one moment. He has been enormously successful, and you will find from his testimony he is also a very articulate spokesman. If sometimes mistaken, he is still very good. Welcome.

Mr. COLACCINO. Thank you.

Mr. HOAGLAND. Let me also introduce Charles Siegel representing the International Mass Retail Association; Edward Lenz, representing the National Association of Temporary Services; and Steve Elmont, representing the National Restaurant Association.

Mr. Colaccino, perhaps you can go first.

STATEMENT OF FRANK COLACCINO, VICE CHAIRMAN, EXECUTIVE COMMITTEE FOR PUBLIC AFFAIRS, NATIONAL ASSOCIATION OF CONVENIENCE STORES, AND PRESIDENT AND CHIEF EXECUTIVE OFFICER, DAIRY MART CONVENIENCE STORES, INC.

Mr. COLACCINO. Good afternoon and thank you. I am Frank Colaccino, president and CEO of Dairy Mart, Inc., an Enfield based convenience store chain that operates 1100 stores in 11 States.

Today I appear on behalf of the National Association of Convenience Stores, an international trade association representing 1543 convenience store companies who collectively operate 54,000 stores here in the United States.

You may be surprised to learn that over 80 percent of our members currently provide health insurance for their full-time employees at substantial employer copayment rates. These companies have faced double-digit increases over the past several years, with 1993 being the highest, an 18 percent increase over 1992.

For these and many other reasons, we do see the need for improvements to our Nation's health care system, but we are not prepared to support the President's plan.

The Nation's typical convenience store employs both full and part-time employees. The split is 57 percent full-time and 43 percent part-time. Equally important to an understanding of our work force is the fact that we experience very high employee turnover.

Convenience store clerks spend on average 88 days on our pay-rolls. These issues are important because they lie at the heart of our concern with the proposed employer mandate.

Even though over 80 percent of our member companies offer insurance to full-time store employees, only 16 percent currently offer coverage to part-timers. Moreover, to accommodate the turnover issue, most of our member companies offer insurance coverage only after completion of 4 months on the job, eliminating coverage for those employees whose tenure falls short of 120 days.

But here is my point: When you combine the fact that the typical convenience store owner does not cover part-time employees who make up 43 percent of the labor force, the reality is that at any given time most companies are only providing coverage for a fraction of the total work force.

Therefore, an employer mandate for first day, 80 percent copay coverage given the vast number of employees we would have to add to our health insurance rolls is potentially devastating.

Our association recently did a survey of our members to determine health care costs and industry opinion on various proposals

to reform the Nation's health care system. In essence, we found 83 percent of our members do offer insurance subject to waiting periods and full-time status. We also found that 17 percent of our members do not currently offer insurance benefits.

Overall, we have determined that the industry's average cost of providing insurance to be 4 percent of payroll. Using 1992 statistics, in which industry's payrolls totaled \$6 billion, this means that health care costs approached \$240 million at present for our industry.

As we understand the Clinton proposal, employer contributions would be capped at 7.9 percent, or nearly twice what we are currently paying. Therefore, if we simply double the industry's current \$240 million charge for health care benefits to \$480 million, it is easy to see the effects on pretax profits. In 1992 the industry's pretax profits were \$557 million.

I should also say that while we are aware of the small business subsidies provided by the proposal, it is our view that few of our members will qualify as most have more than 75 employees. In addition, we relied on the 7.9 percent payroll cap for our cost estimates, since we believe at this point that it will be imposed in almost all industry cases given the vast number of new employees that will be added and that will become eligible for health insurance benefits.

But the industry's economic picture is not our only concern. We are also worried that the 7.9 percent payroll cap number is unrealistic. Indeed, we are skeptical that it can possibly provide enough money to cover everyone, even with the savings we all seek from health care reform.

We surveyed our members to learn what it would cost to provide insurance for all our employees at today's prices, then we compared that cost with costs using the 7.9 percent payroll approach. As expected, when we calculated 7.9 percent of payroll for a sampling of companies, we did find that the figures were lower than today's prices, so much lower, in fact, that we have a hard time believing them.

For example, one California company employing 1,500 people, we know at today's prices insurance for all would cost \$2.164 million. However, when we applied the 7.9 percent cap to the company's \$19.94 million payroll, the most the company would pay under President Clinton's proposal is \$1,575,260, 27 percent less than today's prices.

At my company, we currently cover 1640 of our 5008 Dairy Mart employees. This costs us \$5.1 million per year. To provide the same coverage for all of our employees would cost us \$12.5 million. If I apply the 7.9 percent cap to our \$70 million payroll, you can see that our maximum exposure under President Clinton's plan would only be \$5.5 million, 58 percent lower than it would cost today.

The point of all this, quite simply, is that the National Association of Convenience Stores is very skeptical that such dramatic savings can be wrung from the health care system right away. We have little confidence that the employer portion can remain capped at 7.9 percent or that it will not have to be raised to some other number as part of the original legislation.

While ultimately we share the view much can be saved through necessary reforms, we find it difficult to believe startup savings of the magnitude envisioned are possible. The National Association of Convenience Stores is not saying that the government should not have a role in health care reform. Indeed, it must. That role, we believe, should be to act as a facilitator for change to improve the system. This is, we think——

Mr. HOAGLAND. Mr. Colaccino.

Mr. COLACCINO. Just give me 30 seconds and I will be over. This is we think a more prudent approach than the vast bureaucracy we see in the current proposal. There are clearly steps Congress can take right now to alleviate much of what is wrong with our health care system.

Reform medical malpractice laws is one, achieve uniform streamlined paperwork is another, and impose Federal preemption of State laws that require excessive coverage and restricts managed-care plans.

Additionally, we believe strongly in the power of programs to encourage consumer empowerment.

These fundamental and incremental reforms can be enacted by Congress and should be as a necessary first step. And we stand ready to help. To do so may well provide enough cost relief to advance the popular and noble objective of universal coverage.

As for employer mandates, there is no doubt in our mind that without some concrete evidence of savings health care reform can produce, the risk of crippling small and large business is real. We urge you to carefully evaluate the potential dramatic effects that such a mandate can produce before a complete understanding of the savings we all seek is certain.

Thank you.

Mr. HOAGLAND. OK, thank you.

[The prepared statement follows:]

**STATEMENT OF FRANK COLACCINO
ON BEHALF OF THE
NATIONAL ASSOCIATION OF CONVENIENCE STORES (NACS)**

Good afternoon, Mr. Chairman and members of the committee — I am Frank Colaccino, President and C.E.O. of Dairy Mart Convenience Stores, Inc., an Enfield, Connecticut based convenience store chain that operates 1100 stores in 11 states.

INTRODUCTION OF NACS

Today, I appear on behalf of the National Association of Convenience Stores (NACS), an international trade association representing 1543 convenience store companies who collectively operate 54,000 stores here in the U.S. As Chairman of the Public Affairs Committee of NACS, I wish to thank you for this opportunity to present our industry's views on the President's proposal to mandate employer paid health benefits.

Like many industries, the convenience store industry is grappling with today's high cost of providing health benefits. You may be surprised to learn that over 80 percent of our industry's companies currently provide insurance for full time store employees at substantial employer co-payment rates. These companies, like our counterparts in other industries, have faced double digit increases over the past several years with 1993 being the highest, at 18 percent higher than 1992.

For these and many other reasons, we do see the need for improvements to our nation's health care system, but we are not prepared to support the President's call for mandated benefits. Let me explain why.

TODAY'S TYPICAL CONVENIENCE STORE

The nation's typical convenience store employs both full and part-timers. The split is 57 percent full time to 43 percent part time. Equally important to an understanding of our workforce is the fact that we experience very high employee turnover. Indeed, convenience store clerks spend an average of only 88 days on our payroll. These issues are important because they lie at the heart of our concern with the proposed employer mandates. Even though over 80 percent of our member companies offer insurance to full time store employees, only 16 percent currently offer coverage to part-timers.

Moreover, to accommodate the turnover issue, most of our member companies typically offer insurance coverage only after a reasonable waiting period — usually the completion of four months on the job — eliminating coverage for those employees whose tenure falls short of 120 days.

But, here's my point — when you combine the fact that the typical convenience store owner does not cover part-time employees who make up 43 percent of the labor force with a four month tenure requirement, the reality is that, at any given time, most companies are only providing coverage for a fraction of their total workforce. Therefore, an employer mandate for first-day, 80 percent co-pay coverage, given the vast number of employees we would have to add to our health insurance rolls is potentially devastating. Let me share a few quick numbers with you to illustrate the economic impact on our industry.

**ESTIMATED COST TO CONVENIENCE STORE INDUSTRY
OF EMPLOYER MANDATES**

Our association recently did a survey of our members to determine health care costs and industry opinion on the various proposals to reform the nation's health care system. In essence, we found that 83 percent of our members do offer insurance subject to waiting periods and full-time status. We also found that 17 percent of our members do not currently offer insurance benefits. Overall, we have determined the industry's average cost of providing insurance to be 4 percent of payroll. Using 1992 statistics in which the industry's

store payrolls totaled \$6 billion, this means that health care costs approach \$240 million at present for our industry.

As we understand the Clinton proposal, employer contributions would be capped at 7.9 percent, or nearly twice what we're currently paying. Therefore, if we simply double the industry's current \$200 million charge for health benefits to \$480 million it is easy to see the effect on pre-tax profits. In 1992, the industry's pre-tax profits were \$557 million, a figure that would be substantially eroded if we are required to double our health care expense.

I should also say that while we are aware of the small business subsidies provided by the proposal, it is our view that very few of our members will qualify as most have more than 75 employees. In addition, we rely on the 7.9 percent cap on payroll for our cost estimates since we believe, at this point, that it will be imposed in almost all industry cases given the vast numbers of new employees that will become eligible for health care benefits.

But, the industry's economic picture isn't our only concern. We are also worried that the 7.9 percent payroll cap number is unrealistic. Indeed, we are skeptical that it can possibly provide enough money to cover everyone even with the savings we all seek from health care reform. Let me explain.

UNIVERSAL COVERAGE AT TODAY'S PRICES COMPARED WITH A 7.9 percent PAYROLL CAP

Mr. Chairman, we also surveyed our members to learn what it would cost to provide insurance for all employees at today's prices. Then we compared that cost with costs using a 7.9 percent of payroll approach. As expected, when we calculated 7.9 percent of payroll for a sampling of companies we did find that the figures were lower than today's prices -- so much lower in fact, that we have a hard time believing them. Let me quickly show you what I'm talking about.

For one California company employing 1,500 people, we know that at today's prices insurance for all would cost \$2,164,000. However, when we apply the 7.9 percent cap to the company's \$19,940,000 million payroll, the most that company would pay under President Clinton's proposal is \$1,575,260 -- 27 percent less than today's prices.

For a Kansas operator with 31 stores, that same calculation compares today's quote of \$191,023 with 7.9 percent of its \$2,091,544 payroll or \$165,231 -- a 14 percent savings.

Let me also share the calculations of an Oregon NACS member. At today's prices, insurance for everyone in this 102 store chain is quoted at \$1.3 million. Under the President's plan, the 7.9 percent cap would be imposed on that company's \$9.8 million payroll for a cost of only \$774,000 -- a 40 percent savings.

Finally, let me share my company's numbers with you. We currently cover 1640 of our 5008 Dairy Mart employees. This costs us \$5.1 million each year. To provide the same coverage for all of our employees would cost us \$12.5 million. If I apply the 7.9 percent cap, to our \$70 million payroll, you can see that our maximum exposure under the President's plan would only be \$5.5 million--58 percent lower than it would cost today.

Mr. Chairman, the point of all of this is, quite simply, that the National Association of Convenience Stores is very skeptical that such dramatic savings can be wrung from the health care system right away. We have little confidence that the employer portion can remain capped at 7.9 percent or that it won't have to be raised to some other number as part of the original legislation. While ultimately, we share the view that much can be saved through necessary reforms, we find it difficult to believe that start-up savings of the magnitude envisioned are possible.

CONCLUSION

Mr. Chairman, the National Association of Convenience Stores is not saying that the gov-

ernment shouldn't have a role in health care reform. Indeed, it must. That role, we believe, should be to act as a facilitator for change to improve the system. This is, we think, a more prudent approach than the vast bureaucracy we see in the current proposal. There are clearly steps Congress can take right now to alleviate much of what is wrong with our health care system. Among these are measures to reform medical malpractice laws, achieve uniform and streamlined paperwork, and impose federal preemption of state laws that require excessive coverage and restrict managed care plans. Additionally, we believe strongly in the power of programs to encourage consumer empowerment. These fundamental and incremental reforms can be enacted by Congress and should be as a necessary first step. And we stand ready to help. To do so may well provide enough cost relief to advance the popular and noble objective of universal coverage.

As for employer mandates, there is no doubt in our mind that without some concrete evidence of the savings health care reform can produce, the risk of crippling small business is real. We urge you to carefully evaluate the potential dramatic effects that such a mandate can produce before a complete understanding of the savings we all seek is certain.

Mr. Chairman, this concludes my prepared statement and I'd be happy to answer any questions you may have.

**STATEMENT OF EUGENE L. HARTWIG, SENIOR VICE
PRESIDENT, KELLY SERVICES, INC.**

Mr. HOAGLAND. Mr. Hartwig.

Mr. HARTWIG. Mr. Chairman and members of the committee, I am Eugene Hartwig, senior vice president of Kelly Services, the Nation's leading provider of office and clerical temporary help.

Kelly Services supports legislation to ensure universal health care coverage and Kelly is willing to pay its fair share. Our president and CEO, Terence Adderley, has gone on record with Members of Congress stating his support of universal coverage.

Congressman Levin visited us 3 weeks ago to talk with our employees about health care reform. He recognized that employment in the temporary help industry differs from full and part-time employment. He urged that we ask for time to tell that story to this committee. We thank you for inviting us to do so.

Here are some facts. Temporary employees represent just over 1 percent of the U.S. work force. On any given day that is roughly 1.5 million people. In the course of a year, some 7 million persons work as temporary employees in this country. Each year, 50 percent of these temporary employees work 3 weeks or less. Let me repeat that. Three weeks or less for 50 percent of those who work in the temporary help industry for any one temporary help company. Ninety percent work less than 1,000 hours a year. Turnover among temporary employees is on the order of 500 percent annually.

These numbers demonstrate that the temporary help industry is unique and different in many ways from full-time or part-time employment. Temporary employers bring together individuals who have short-term employment needs and customers who have short-term jobs to be done. Temporary employment by its nature is not ongoing, whereas full-time and part-time employment is.

Both our temporary employees and our customers depend on this flexibility. Most importantly the vast majority of our employees are not available for extended assignments. On the customer side, temporary employees typically undertake short-term projects for customers who need people for a few days or a few weeks.

Temporary help has been an important and necessary service for millions of job seekers and hundreds of thousands of businesses for nearly 50 years.

We can support the employer mandate in H.R. 3600 if it is made workable for the temporary help industry. H.R. 3600 provides a formula for prorating the premium for part-time employment, but that formula does not work for temporary help.

The temporary help industry deserves a different solution which takes into account the size, some 7 million employees a year, and unique characteristics of the industry's employment. This solution could be as simple as a FICA type payroll tax related to wages paid.

We want health care reform to work, to be a genuine improvement over the system now in place. We stand ready to work with you in that effort.

Thank you very much.

Mr. HOAGLAND. Thank you.

[The prepared statement follows:]

TESTIMONY OF EUGENE L. HARTWIG
 SENIOR VICE PRESIDENT
 KELLY SERVICES, INC.
 BEFORE THE HOUSE COMMITTEE ON WAYS AND MEANS
 ON THE EMPLOYER MANDATE AND RELATED PROVISIONS OF THE
 HEALTH SECURITY ACT (H.R. 3600)
 FEBRUARY 3, 1994

Mr. Chairman and members of the Ways and Means Committee. I am Eugene Hartwig, Senior Vice President of Kelly Services, the nation's leading provider of office and clerical temporary help. I also serve as member of the Company's Managing Committee.

KELLY SERVICES, INC.

Kelly Services, Inc. is a Fortune 500 services company that provides temporary help and other staffing and human resources services through more than 900 Company-owned offices in the United States. Kelly does not franchise. Kelly also has offices in Canada, Mexico, the United Kingdom, Ireland, France, the Netherlands, Denmark, Norway, Australia and New Zealand. Kelly accounts for about 10 percent of the temporary help industry in the United States.

Although our core business is office/clerical, accounting and records management support, Kelly also provides temporary help services in --

- Marketing, such as demonstrating and selling products, telemarketing and assisting at conferences and trade shows;
- Technical, such as manufacturing, science, data processing, administrative and engineering support; and
- Light industrial, such as shipping and receiving, light assembly, cafeteria and maintenance work;

Last year alone, Kelly assigned 550,000 of its employees to temporary job assignments at work locations across the nation and paid over \$1.4 billion in wages and wage related benefits to employees in the United States. We screened, tested and registered more than one million individuals for the qualified employee pool from which we make assignments.

KELLY SUPPORTS HEALTH CARE COVERAGE FOR ALL

Kelly Services supports the need for legislation to ensure universal health care coverage. And Kelly is willing to pay its fair share to accomplish that objective. Our President and CEO, Terence Adderley, has gone on record with members of Congress to that effect on several occasions.

Congressman Sander Levin visited us three weeks ago to talk with our employees about health care reform. He recognized that employment in our industry differs from "full" or "part-time" employment and urged that we ask for time to tell that story to this Committee. We thank you for inviting us to do that.

WHAT IS TEMPORARY HELP?

Here are some facts --

- Temporary employees represent just over one percent of the U.S. workforce. On any given day, that's roughly 1.5 million people.
- More than seven million persons work as temporary employees at one time or another over the course of a year in this country, many of them for three or four different temporary help companies.
- Fifty percent of those who work on temporary assignments work three weeks or less over the course of a year for any one temporary help company.
- Ninety percent of all temporary employees work less than 1000 hours for any one temporary employer in a year.
- Turnover among temporary employees is on the order of 500 percent annually.

As startling as these numbers seem, they are normal for our industry and for Kelly. Temporary employment simply operates differently and serves differing employment and economic needs than either full or part-time employment. Temporary employers bring together people who have short-term employment needs and match them with customers who have short-term jobs to be done. Part-time employees make a commitment to work a fixed part-time schedule that is on-going over a period of time; temporary employees do not.

Temporary employees change work sites when they receive a new assignment. They receive their assignments by telephone and have minimal contact with Kelly branch offices. Their work schedules frequently vary and depend upon the requirements of our customers.

Temporary employees retain control over their time cards and submit them at their convenience. They may work a week and mail in their time card on Friday, or they may hold it for a period of time before submitting it for payment.

Both our temporary employees and our customers value and depend on the flexibility of temporary employment. The vast majority of our employees are not available for extended assignments. One of the reasons temporary employment is so attractive to millions of job seekers is because it fills an employment need which can be tailored to their special requirements.

For example, tens of thousands of Kelly employees are teachers or college students for whom temporary help jobs are ideal during semester breaks or over the summer. For parents who want to be at home when their children are not in school, the availability of temporary help assignments can accommodate their schedules very well. Retirees use temporary help to supplement their income; others use it as a means to reenter the workforce or as a bridge or safety net while between jobs.

The short duration of most temporary jobs, three to four weeks a year on average, belies the contention sometimes made that temporary workers are displacing full-time employees.

On the customer side, temporary employees typically undertake short term projects for customers who need additional people for a few days or weeks. They fill in when seasonal workloads increase, in cases of vacations or illness, and when new products are being tested or introduced.

THE EMPLOYER MANDATE IN H.R. 3600The Payment Mechanism

Kelly Services can support the employer mandate in H.R. 3600 if it is made workable for the temporary help industry.

H.R. 3600 provides a formula for prorating the premium that was designed to accommodate part-time employment. The formula does not work, however, for temporary help where the length of work assignments are unpredictable, of typically short duration and involve multiple temporary help and other employers.

The temporary help industry deserves a different solution which takes into account its size -- some seven million employees a year -- unique characteristics, and the positive role it plays in the economy for insuring flexibility and quick response to changing circumstances. The solution could be as simple as a FICA-type payroll tax related to wages paid.

Administrative Concerns

We are also concerned about how the administrative requirements and responsibilities imposed by the employer mandate would impact our Company and our industry.

Under H.R. 3600, Kelly would be required to obtain detailed enrollment information on each of the 550,000 employees we assign to temporary jobs. Half of those are people who will be working for us for three weeks or less over a period of time. We would also be responsible for keeping this information current at all times or face serious liabilities and penalties for incorrect reporting and untimely payment of premiums.

At Kelly, the reality is that we have a hard time getting temporary employees to keep us informed about address changes so that we can properly direct their paychecks. In the benefits area even our full-time employees, with whom we have contact on a daily basis, fail to give us timely notice of critical status changes, such as marital status. In our experience, this is true of all employers.

The compelling numbers of temporary employees hired annually by Kelly alone, coupled with their short and unpredictable tenure creates an imposing administrative workload with impractical cycle times. Our organization's ability to maintain high data integrity regarding enrollment, collection and reporting in the face of this scenario is severely compromised.

These factors, in our view, render the data gathering requirements of the employer mandate in H.R. 3600 all but unworkable in our industry.

KELLY WANTS HEALTH CARE REFORM TO WORK

Kelly Services wants health care reform to work, to be a genuine improvement over the system now in place. We stand ready to work with you in that effort.

STATEMENT OF CHARLES SIEGEL, MEMBER, BOARD OF DIRECTORS, INTERNATIONAL MASS RETAIL ASSOCIATION, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, 50-OFF STORES, INC., SAN ANTONIO, TEX.

Mr. HOAGLAND. Mr. Siegel.

Mr. SIEGEL. Mr. Chairman and members of the committee, thank you for this opportunity to comment on the employer mandate and related options in the administration's Health Security Act. I am Charles Siegel, president, chairman and CEO of 50-Off Stores located in San Antonio, Tex.

Before I begin, I would like to briefly describe the organization that I am representing today. The International Mass Retail Association, IMRA, represents more than 160 mass retailers that include discount department stores, warehouse clubs, off price stores, as well as 550 suppliers.

Collectively, IMRA retail members operate more than 54,000 stores in the United States and abroad and employ millions of people. Our retail members represent the overwhelming majority of the \$202 billion mass retail industry in the United States.

I am here today to ask the committee to admit IMRA's written statement for the record, but I would also like to share with the committee the effect that an employer mandate would have on my company, 50-Off Stores. We opened the first 50-Off Store in 1986 in San Antonio, Tex., but as of this month, we will have grown to operate 111 stores in 13 States, in spite of difficult economic times recently for retailers.

Although our success may be attributed to many factors, it has been due in part to the quality of our employees and also our ability to control costs. 50-Off's targeted customer typically has a low to moderate income, is likely to be a single parent or a dual-wage earning family member who has little or no discretionary income; therefore, we locate our stores in areas that are heavily represented by this customer.

We are able to provide recognizable brand merchandise at prices significantly lower than they would pay at traditional department or specialty stores. We also provide full-time and part-time employment to over 3,000 people in these same areas where statistics definitely show that unemployment far exceeds national averages.

About 40 percent or 1200 of our employees work full-time and the other 60 percent or 1800 of our employees work part-time.

In order to attract quality employees who can help our company grow and prosper, we offer a self-funded health care plan to all employees who work at least 30 hours a week. Our plan protects its participants against catastrophic loss and offers a choice of deductible options that allow participants to decide how to spend their health care dollars.

This allows the company to maintain total plan cost that, per participant, are considerably lower than the national average.

Of these total plan costs, 60 percent are funded by the company at a cost of about 3.2 percent of payroll. Unfortunately, under an employer mandate such as the one in the administration's Health Security Act, our costs would more than triple.

Even if it were capped at 7.9 percent of payroll, company health care costs would increase by more than \$1 million per year.

Other costs the company would incur, relate to the administrative burden to comply with the reporting requirements of the multiple regional alliances. Companies such as ours, and I know I speak for the majority of the companies in our industry, simply cannot afford these types of increases without decreasing costs elsewhere.

Indeed, we would be forced to reduce payroll costs by eliminating some 250 part-time jobs, which represent almost 14 percent of all part-time jobs in our company.

In addition to losses in income to our poor customers who depend on part-time jobs for most of their discretionary income, undoubtedly it will result in lower sales and, therefore, further elimination of part-time as well as full-time jobs.

We believe there are many ways to control health care costs without loss of jobs and, therefore, urge you to oppose onerous mandates and burdensome administrative policies. We ask that you place the decisionmaking on health care options with individuals and their employers who together can maintain effective control.

Thank you.

Mr. HOAGLAND. Thank you, Mr. Siegel.

[The prepared statement follows:]

**Statement of the International Mass Retail Association
on the Employer Mandate and Related Provisions in the Health Security Act**

February 3, 1994

Mr. Chairman and Members of the Committee, thank you for this opportunity to comment on the employer mandate and related provisions in the Administration's Health Security Act. I am Charles Siegel, President, Chairman, and CEO of 50-Off Stores located in San Antonio, Texas. Before I begin, I would like to briefly describe the organization that I am representing today.

The International Mass Retail Association (IMRA) represents more than 160 mass retailers that include discount department stores, warehouse clubs, and off-price stores, as well as 550 suppliers. Collectively, IMRA retail members operate more than 54,000 stores in the U.S. and abroad, and employ more than 1.5 million people. Our retail members represent the overwhelming majority of the \$202.2 billion mass retail industry in the United States.

The discount retail sector has been characterized as "a new engine for job creation." Retailing has contributed to our nation's economic vitality by generating over 300,000 new jobs each year for the past two decades. Since 1991, the number of jobs in the discount retail industry alone increased over 48 percent. Out of the 1.9 million new jobs created in every business sector in the entire country since 1991, over 20 percent were in the discount retail industry. The job growth in the discount retail industry may be attributable to a number of factors. Foremost is the fact that because of the recent recession, disposable income has declined, thus forcing consumers to become more "cost conscious." IMRA members, operating efficiently, and in large volumes, are able to provide the consumer with the best quality product at the lowest possible price. Consumers now recognize that even in a prosperous economy, the best values are found in discount retail stores.

Second, retailing jobs have become more attractive to people seeking flexible employment such as the single parent, students, and senior citizens. Discount retailers, while offering nontraditional working hours like evenings and weekends, also have a reputation of offering high quality benefits including health care coverage, profit sharing, 401(k) plans, dental care, and life insurance. Although these generous benefits are normally offered to full-time workers, some retailers choose to provide them to the entire workforce. Full-time workers in retailing are defined as those working between 28 and 30 hours per week as compared to other industries that typically use a 40-hour work week. Others look to the retail industry because of the available part-time employment opportunities. Studies show that over 70 percent of part-time employees are individuals who prefer or need part-time employment. In today's highly diverse society, this particular type of job opportunity is crucial.

IMRA is greatly concerned with the financing provisions in the Health Security Act and the effect on not only the retail industry, but on job loss in general. In particular, IMRA is opposed to the mandate that employers must pay 80 percent of the costs of the health insurance premium for all workers regardless of the number of hours worked per week. This mandate, which is originally capped at 7.9 percent of payroll, is the equivalent of a huge payroll tax which will undoubtedly result in massive job losses. Numerous studies have indicated that employer mandates will put millions of jobs at risk. The result will inevitably be lower wages, reduced benefits and fewer part-time jobs.

A study by the Employment Policies Institute dated September 1993 concluded that requiring employers to pay for workers' health insurance expenses will increase labor costs leading to the loss of 3.1 million jobs. These job losses will be concentrated in just a few industries with retail trade as the second largest affected industry. This study estimates that retailers will eliminate 726,000 jobs. In addition, a CONSAD research study found that any health care reform plan requiring employer mandates could put 7.5 to 18 million jobs at risk in terms of reduced wages, reduction of other benefits, and potential cuts in hours worked. Job loss estimates range from 400,000 to over 1 million as a result of a mandate proposal. These are just a few of the many empirical studies concluding that employer financing mandates threaten job losses.

With an employer mandate to provide health coverage, retailers will be forced to consolidate part-time jobs into full-time jobs. IMRA estimates that approximately 20 percent of the discount retail industry jobs will be eliminated or seriously threatened under this plan. As much as we would like to, discount retailers simply cannot absorb the additional burdens. To provide value to the customer, discount retailers must operate on very low profit margins. Other industries can reduce their cost impact by changing their production techniques, such as substituting capital equipment or high-skill workers for low-wage uninsured labor. The retail industry, however, is very labor-intensive, and has no means of reducing the additional burden other than consolidating part-time workers and reducing wages and benefits. Therefore, any tax on labor threatens jobs no matter how it is characterized.

The mandate would also jeopardize the application of other reform proposals currently under consideration in Congress. Welfare reform plans, for example, aspire to help public assistance recipients find quality employment. Yet most of the people seeking to move from welfare to work are qualified only for lower-wage positions. They can move up the ladder only if they are given the opportunity to work. But a mandate would vastly increase the cost of hiring these workers, thereby becoming a latent disincentive to hire the typical welfare recipient looking for work.

The effect of an employer mandate will also have a detrimental impact on employer wages and benefits in the short and long term. Employers who do hire additional employees will be forced to offer them lower wages due to increasing labor costs. Many of the generous benefits offered to employees in the retail industry, such as stock options, paid vacations, and life insurance will also have to be reduced or eliminated altogether.

The administrative, collection, and compliance costs of an employment mandate will place additional burdens upon retailers, particularly the costs of covering part-time, temporary, and seasonal workers. Because of the large percentage of part-time workers, the retail industry employs, the requirement that employers pay pro-rated premiums for part-time employees means retailers must perform complex calculations to determine the correct premium payment for each part-time worker. Moreover, many part-time workers hold more than one job with varying hours each week. Attempting to track the employees in order to determine their health care payments would be an administrative and compliance nightmare. The additional burdens and costs to comply with the mandate would outweigh the economic benefit derived from employing part-time workers. Retailers would no longer hire two 15-hour per week part-time workers because they would be better off with one 40-hour per week worker.

The financing provisions in the Administration's plan also threaten an employer's ability to self-insure. Many large retailers have found that through self-funded plans they are able to control the costs of providing health care while maintaining quality coverage for their employees. Through initiatives set up within the company, such as on-site clinics, free health screening, and educational information, and through copayments and deductibles, employers are able to control health care costs by encouraging individual responsibility and preventive care.

Under the Administration's plan, however, most companies would be forced to join a regional alliance rather than maintain a self-insurance plan. This is due to several reasons: first, if the employer remains self-insured and is mandated to provide benefits to all employees, the amount of employee claims are not limited based upon the hours worked. For example, an employee working 15 hours per week could potentially have the same or greater health care costs as a person working 40 hours per week. The premium cap in the regional alliance at least enables the employer to predict the costs based upon the number of hours worked.

Second, the corporate assessment of one percent on self-insured companies forming their own corporate alliance is an additional expense on top of the mandated health care coverage. This tax is completely unfair and burdensome to the self-insured employer because there is no guarantee that their health care costs will be lower than those of employers joining the regional alliance. In addition, there is no guarantee that this tax will remain at one percent. Finally, if the revenue for funding the health care plan falls short, the one percent tax is a likely target for generating new revenue by future Administrations.

Eliminating employer incentives to remain self-insured runs counter to one of the President's basic objectives. By forcing employers into regional alliances, it will take away any incentive to control costs. Employers will not incur the added expense of providing on-site clinics, health care screenings, or other measures if there is no incentive to do so. By requiring them to simply write a check each month to the regional alliance, they no longer become a participant in the health care decision process. Similarly, the employee is also eliminated from the health care purchasing equation. This is exactly the opposite of basic, free market principles. Instead of letting the consumers make decisions on prices and quality, under the Administration's plan, the government makes it for all of us. It discourages individual responsibility and takes away any incentive to educate ourselves on purchasing health care services.

It is clear that employers in the United States provide most of the current financing for health care today. This is an historical fact that really occurred because of the willingness of forward thinking employers to invest in their employees' welfare. However, the fact that employers over the years (since World War II) have voluntarily expanded the benefits provided, as well as significantly increased their expenditures for health care, should not mean that they must be continually burdened with the additional costs imposed under the Administration's plan. It should also remain voluntary. Let the best employers continue to voluntarily offer benefits to attract quality employees.

IMRA supports health care reform and applauds efforts by the Administration and Congress to begin the debate. Our position is clear, however, that any changes made at the expense of the American worker and the U.S. economy is not reform. IMRA believes that necessary changes to the health care system must be made in order to ensure better access to the health care system and to maintain affordable coverage for all individuals. This can be achieved without increased government intervention and without further burdening the American worker and businesses with higher taxes and increased regulation.

In particular, IMRA believes that individuals, and not the government, should be free to make choices on the type of health care coverage they wish to obtain and the doctor they would like to see. In keeping with this philosophy, we would encourage lawmakers to use basic market-reform principles, rather than artificial price caps or other government controls, to maintain high quality, affordable and accessible health care.

The retail members of our association strongly support the concept of medical savings accounts (MSA's) which would bring the consumer, rather than the government, into the health care purchasing equation. This concept is a proven alternative to the current third-party payer system and gives consumers increased choices and promotes individual responsibility. In addition to MSA's, IMRA believes that through insurance market reform, consumers will have guaranteed access to health care. People should not be denied coverage based on preexisting conditions, nor should they be dropped from their health plan when they need it the most.

Additionally, IMRA recognizes that almost one-half of all health care spending in the U.S. is attributed to the administration and billing of health care services. We strongly support measures which standardize billing procedures and streamline administration. IMRA also supports the following: tax equity for the self-employed and uninsured, voluntary purchasing pools for small businesses and individuals, and tax subsidies or vouchers to purchase health insurance for the uninsured, low-income individual not covered under Medicaid.

Also, we would recommend and encourage (possibly through tax incentives) that all individuals carry, at the very least, a high deductible, low-cost, catastrophic health insurance plan to cover the expensive and unexpected occurrences. This is the reason for which insurance was originally created. MSA's would achieve many of these reform measures. With an MSA, payments are made directly from the consumer to the provider and not through a third party, thereby alleviating enormous paperwork tasks and reducing administrative costs. Additionally, an individual with an MSA would carry a catastrophic insurance plan and use money in the account for routine, low-cost health services. Individuals would be in control of how their money is spent on health care and would be free to make their own decisions on the type of coverage they desire.

IMRA looks forward to participating in the continuing debate on health care reform. We welcome the opportunity to discuss further our concerns and ideas with Members of Congress and their staff on this most important issue.

**STATEMENT OF EDWARD A. LENZ, SENIOR VICE PRESIDENT,
LEGAL AND GOVERNMENT AFFAIRS, NATIONAL ASSOCIATION
OF TEMPORARY SERVICES**

Mr. HOAGLAND. Mr. Lenz.

Mr. LENZ. Thank you, Mr. Chairman, members of the committee. My name is Edward Lenz, and I am here on behalf of the National Association of Temporary Services, where I serve as senior vice president for legal and government affairs.

NATS has over 1100 members which operates some 8300 temporary help offices throughout the United States. Temporary help companies employ millions of Americans with special employment needs, such as parents with small children, first-time job seekers, older workers, and students.

Recently our companies have assumed a new and vital role. They are helping to ease the burden on individuals during the current restructuring of the American work force. Temporary work offers displaced workers a critical safety net of income, benefits, and skills training on an interim basis, and often provides a bridge back to regular full-time employment.

We are afraid the cost of mandates could weaken this job bridge for a significant number of temporary workers. Mandates will also impose enormous administrative burdens on temporary help employers and on the government. Annual temporary employee turnover is in the range of 400 to 600 percent, which means that 6 to 9 million temporary employees each year would have to be tracked, enrolled, disenrolled, and enrolled again as they move sporadically in and out of our work force.

If Congress decides to adopt employer mandates, temporary help firms need a mechanism that relates the premium payments to hours worked. Although H.R. 3600 has a formula for computing partial premiums for part-time work, this is unworkable for temporary employers who would have to track the hours and calculate the ratio for millions of temporary employees.

A simple payroll tax should be considered as an option for high turnover employers. And for employees working less than 40 hours in a month, there must be a way to rebate their share of the premiums which does not impose major burdens on the employer.

We also think that any employer that meets certain safeguards should be allowed to form its own corporate alliance. The bill bars employee leasing companies from setting up their own alliances and the administration says temporary help will be considered leasing under this prohibition. We don't think this is fair or necessary.

In conclusion, I would like to stress that NATS supports health care reform. We support removing existing barriers to coverage and our members are willing to pay their fair share of the cost of expanding access to coverage, but it is our hope that Congress could find a way to achieve meaningful health care reform without employer mandates.

Thank you for the opportunity to be here today. We look forward to working with the Congress to help formulate a health reform bill that our industry can enthusiastically support.

Mr. HOAGLAND. Thank you Mr. Lenz.

[The prepared statement follows:]

Statement of Edward A. Lenz
 Senior Vice President, Legal and Government Affairs
 National Association of Temporary Services
 Before the House Ways and Means Committee
 on the Employer Mandate and Related Provisions of the
 Health Security Act (HR 3600)
 February 3, 1994

This statement is submitted on behalf of the National Association of Temporary Services (NATS). NATS's over 1,100 member temporary help and staffing services firms operate some 8300 offices throughout the U.S. and provide approximately 85% of the industry's \$25 billion in current annual sales. An estimated 1.6 million Americans work as temporary employees every day. For the reasons stated below, NATS has serious concerns regarding employer mandates and believes that Congress should first try non-mandate approaches to health care reform.

Role of Temporary Help in the Economy

Temporary work has for over 50 years been a way for individuals with special employment needs to find meaningful and profitable work. Parents (in most cases women) with small children who cannot or do not wish to commit to full-time employment, people looking for first time work who want to "test the waters," older workers looking to stay active and supplement their incomes, and students needing summer work all look to temporary help companies to meet their needs. These still make up the great majority of temporary employees.

In today's economic environment, temporary help companies are assuming a new and vital role. For displaced employees, temporary work can provide a critical safety net that offers income and other benefits, unemployment insurance and workers' compensation protection until regular, full-time work can be found. Moreover, these jobs themselves often are a bridge to regular, full-time employment by giving workers an opportunity to gain new skills (e.g., computer training) and experience with a variety of potential employers.

Temporary help companies also play an important role in helping American businesses achieve the flexibility and productivity essential in today's global economy. By recruiting, screening and training individuals in a wide variety of skill categories from production and clerical workers to managers and professionals, temporary help companies are able to quickly and efficiently supply businesses with personnel to handle a variety of staffing needs such as employee absences, variable production schedules, temporary skill shortages, seasonal workloads, and special projects. Temporary help also can help protect full-time employees from downturns in demand by helping companies maintain their regular staffs at optimum levels, thus mitigating the firings and layoffs that accompany business cycles and the restructuring of industries.

Employer Mandates Will Reduce Employment Flexibility and Will Cost Jobs

NATS has serious concerns regarding employer mandates because they will reduce employment flexibility and will cost jobs. While there has been much debate over the extent of job loss as a result of employer mandates, job losses could be significant in the temporary help industry, particularly at lower wage levels. Average wages in the temporary help industry are approximately \$8.00 per hour. These jobs will be especially vulnerable, even if the government subsidizes part of the cost since, at lower wage levels, it is harder for employers to adjust to higher labor costs by cutting pay rates, as employers of higher-paid workers almost certainly will do in order to mitigate the impact of mandated health costs.

Because of the "transitioning" function of temporary employment previously discussed, any significant loss of temporary jobs would be especially unfortunate during the current restructuring of the American work force. Employer mandates could significantly reduce the positive intermediary role temporary work is playing in helping ease the burden on individuals.

The Administration's Proposal Would Create Major Administrative Complexities for Temporary Help Employers and the Government

Temporary help companies are unique among employers in regard to employee turnover. Because of the special employment function temporary help companies perform, employee turnover is extraordinary. The great majority of temporary employees work for very short periods of time (about four weeks on average) and their work patterns are sporadic and unpredictable. Accordingly, while an estimated 1.6 million Americans work as temporaries on any given day, the total number of individuals who work as temporaries for some period during the course of a year is much higher. Average industry turnover is estimated to be in the range of 400-600 percent annually which means 6 to 9 million Americans a year work as temporary employees.

For the above reasons, mandated health coverage would create very significant costs for both temporary help employers and for the government. Millions of temporary employees would have to be tracked, enrolled, disenrolled, and enrolled again as they move in and out of the work force, creating enormous administrative problems not only for temporary help employers, but for the regional alliances that would be obligated to enroll them.

A Payroll-Based Payment Mechanism is Essential for High-Turnover Employers

If temporary help employers are required to pay for health coverage for their employees from day one, they must have a payment mechanism that relates the payment to the work actually performed. HR 3600 attempts to address this issue by allowing a partial premium to be paid for employees working at least 40 but less than 120 hours in a given month (120 hours in a month being considered "full-time") based on the ratio of the number of hours worked in excess of 40 to 120.

Although the bill provides for pro rata payment, it does it in a way that will not be simple to administer since companies will have to track the hours of service of every employee and calculate the ratio of hours worked in order to determine the percentage of premium that must be paid. While, as employers, we are opposed to new payroll taxes, if mandates are imposed, a simple payroll tax should be considered, *at least as an option*, for high-turnover employers such as temporary help firms.

A payroll tax would be simpler and would ensure that the applicable percentage cap is applied to each individual's wages, thus ensuring that employers only pay for actual hours worked. The current formula, by treating "full-time" as only 120 hours in the month (30 hours per week) means that temporary help employers would pay a full-time premium for thousands of workers who work less than what is normally considered to be full-time (i.e., 35-40 hours per week). At a minimum, the Administration's part-time formula should use 160 (or 140) as the denominator of the fraction.

In addition to the need for a payroll-based payment method, there are a number of other issues that Congress should address in connection with HR 3600 insofar as temporary help employers are concerned. These are discussed below.

Temporary Help Firms Should Not Be Barred from Establishing Corporate Alliances or from Covering Their Temporary Employees Under Such Alliances

HR 3600 allows employers with more than 5,000 full-time employees to set up their own health plan (i.e., "corporate alliance") provided that the plan meets certain requirements. Certain employers, however, may not establish such plans, including *"an employer whose primary business is employee leasing"* (Section 1311(b)(2)(A)). In addition, part-time, seasonal, and temporary employees are ineligible to enroll in a corporate alliance.

NATS has been advised that employee leasing firms are excluded from establishing their own corporate alliances because of concern with abuses relating to so-called multiple employer welfare arrangements ("MEWAs"). We are advised that "employee leasing" is intended to include temporary help service firms. While there are basic differences between temporary help and employee leasing, there is no policy reason for excluding *any* group of employers from establishing their own alliances, provided they meet the safeguards set forth in the bill applicable to such plans, such as ERISA compliance and strict disclosure and reserve requirements. Nor is there any reason why corporate alliance employers should not have the option to cover their part-time and temporary employees if they can develop a feasible mechanism for doing so.¹

Any Subsidies Relating to Low Wage Workers Should be Available to All Employers, Not Just Small Employers

There is no policy reason to provide subsidies (in the form of lower premium caps) for low income workers who work in small firms, but not in large ones. The disincentive to hire such workers will be the same in either case. Providing the subsidies only to small firms creates an unwarranted discriminatory advantage in favor of smaller firms who are often in direct competition with large firms -- especially in the temporary help industry where capital requirements are low and economies of scale minimal. Moreover, because the Administration's bill caps premiums based on *aggregate* payroll, employers who happen to have primarily low wage workers would pay less than employers with both low and high wage workers, again creating an unfair competitive advantage.

To address the above problems, we suggest that (a) any subsidy for low wage workers be provided to *all* companies employing such workers, and (b) that the applicable subsidy be applied only to the individuals whose wages fall within the subsidized category, not to the employer's aggregate payroll.

¹ Very few temporary help companies would be able to meet the current threshold of 5000 full-time employees. However, if the threshold is lowered significantly, many more temporary help firms would be able to qualify and any exclusion would have a much broader discriminatory impact on our industry.

**A Rebate Mechanism Must be Established for Employees
Who Work Less Than 40 Hours in a Month**

The Administration's bill treats employees who work less than 40 hours per month as though they were unemployed. Hence, employers are not obligated to pay premiums on behalf of such individuals or to withhold the employee's share of the premium.

Most NATS members pay employees on a weekly basis and therefore will deduct the family share weekly. If an employee ends up not working 40 hours in a month, the employee may be entitled to a rebate of the family share deducted from his or her paycheck. A mechanism must be developed for providing such rebates. To avoid placing a major paperwork burden on employers, employees should be required to obtain the rebate from the regional alliance. Another approach would be to simply exempt employers of part-time and temporary employees from having to withhold the employee's share. Instead, the employee could pay the appropriate family share directly to the alliance.

Congress Should First Try Non-Mandate Solutions to Health Reform

Eighty-five percent of Americans, including most temporary employees, already have health insurance coverage. A great many of those who are not currently insured would get coverage by improving access to affordable coverage and expanding Medicaid, which other proposals would do. Some have estimated that if such voluntary provisions expanding access are implemented, as few as 5 percent of Americans would be left without insurance. Employer mandates would be an extremely heavy-handed and expensive way to get this last group covered. As previously stated, employer mandates would deprive both employers and employees of flexibility. This would be especially harmful to temporary employees because most work for very short periods of time and primarily need to supplement their cash incomes.

NATS does, however, support health reform proposals that would expand access and control costs without employer mandates and without the extensive government regulation contemplated by HR 3600. We think Congress should enact non-mandate provisions that would increase health coverage and reduce costs through such proposals as: (1) *voluntary purchasing cooperatives* that would allow small businesses to pool their purchasing power, (2) *health insurance reforms* that would require community rating (with appropriate adjustments for age, sex, etc.), prohibit pre-existing condition clauses, and guarantee availability, renewability and portability, and (3) *changes in the tax laws* to limit the exclusion and deductibility of health costs in order to discourage employers from providing unlimited insurance coverage and to encourage individuals to be more discriminating health care consumers.

* * * * *

NATS is committed to working with the Administration and with Congress to help formulate the details of health care reform legislation, especially insofar as it relates to temporary help employers and temporary workers, so that our industry can enthusiastically support enactment of a fair and effective health reform law.

STATEMENT OF STEPHEN E. ELMONT, PRESIDENT, NATIONAL RESTAURANT ASSOCIATION, AND PROPRIETOR, MIRABELLE, BOSTON, MASS.

Mr. HOAGLAND. Mr. Elmont.

Mr. ELMONT. Thank you. My name is Stephen Elmont. I am the proprietor of Mirabelle, a 50-seat restaurant in Boston. As president of the National Restaurant Association, I am here to express our serious apprehension about the health care reforms proposed by President Clinton and particularly the employer mandate.

The restaurant industry is huge, as you probably know. There are approximately 730,000 food service units in America today. We employ 9 million people. Included in this number are millions of part-time workers, students, and moonlighters.

We are among the most labor-intensive businesses in the United States. It takes a lot of people to serve a meal to our customers.

The restaurant industry is also diverse. Our association is composed of virtually every kind of food service company. We have large corporations, and we have an immense base of mom and pop mainstream business operations.

In fact, over 70 percent of the eating and drinking places in America have sales of less than \$.5 million a year.

Such size and diversity does not foster easy consensus, however, we all agree that the additional out-of-pocket cost and bureaucratic responsibility of employer mandates will devastate our industry irrespective of any subsidies offered to low and average-waged small businesses.

For most restaurateurs, the cost of the Health Security Act would be enormous.

For Larry Goldstein, who owns a 250-seat restaurant in Dallas, his health care plan would increase by 52 percent. In Jacksonville, Fla., Famous Amos Restaurants already pays 65 percent employees insurance premiums. The increase in their cost would be 265 percent. In Seattle, Gretchen's of Course would be faced with a whopping 522 percent increase in their current costs.

These are not extreme examples. We have seen them all across the Nation. In fact, the examples I mentioned are restaurateurs who are already providing some insurance for their employees. For tens of thousands of restaurants that do not provide coverage now because it is too expensive, this will be a brand new expense for them as well as their employees.

Not every restaurant looks so dire. According to the Clinton proposal, for example, in my own case, the initial cost of compliance would pretty much be a wash. But I don't for a minute accept the premise I will be unaffected. For one thing, we do not trust the government's financial forecasts.

No prudent business person could look at the government's dismal track record in projecting costs in programs like old-age survivors insurance, disability insurance, and the hospital insurance portion of Medicare and think the White House projections are going to hold.

For another, the complexity of complying with the employer mandate boggles the mind. Here is a 2-page list of the new paperwork rules for employers.

The bottom line to all this is jobs. I might point out that the Joint Tax Committee report on the employer mandate, released yesterday, this book here, agrees with this statement, particularly when it comes to minimum wage workers.

Mr. Chairman, the competition for the restaurant business is intense and primarily driven by price. When you add to our cost something like the mandated payroll tax for health care, we cannot merely take it from profits. Either we raise menu prices, which at best is extremely anticompetitive, or we cut costs in other parts of the business. This inevitably means the cutting of jobs.

The National Restaurant Association is supporting Congressman Jim Cooper and Congressman Fred Grandy's Managed Competition Act. We applaud their efforts, as well as Mrs. Johnson and Andrews.

We believe this bill, with some tinkering around the edges, will bring down health insurance costs to the point where thousands of employers could afford to cover their workers. Bringing millions of Americans into the system without an employer mandate is a far better way to go than sacrificing millions of jobs and the health of the American economy.

Thank you.

Mr. HOAGLAND. Thank you, Mr. Elmont.

[The prepared statement and attachment follow:]

Testimony by

Stephen Elmont
President

National Restaurant Association

February 3, 1994

Mr. Chairman, thank you for the opportunity to present my views this afternoon.

My name is Stephen Elmont. I am the proprietor of Mirabelle, a 50 seat restaurant in Boston, MA.

As president of the National Restaurant Association, I'm here to express our serious apprehension about the health care reforms proposed by President Clinton, in particular the employer mandate.

Before I do that, let me tell you that America's restaurateurs have sought health care reform for years. We have a lot of experience shopping for health insurance for ourselves and for our employees. We know the U.S. needs to make changes so insurance is more affordable *and* more secure. But we think it is a very costly mistake — however well-intentioned — to propose wide-ranging wholesale change in response to a problem that could be addressed more narrowly.

That said, I want to get right at the effects of this proposal on my industry and our workers.

The restaurant industry is huge, as you probably know. There are approximately 730,000 foodservice units in America today. We employ nine million people. Included in this number are millions of part-time workers, students and moonlighters. We are among the most labor-intensive businesses in the U.S.: It takes a lot of people to serve a meal to our customers. In fact a full-time equivalent restaurant employee contributes \$47,300 in sales to the restaurant. A full-time equivalent worker in a grocery store contributes \$160,200 in sales, and a gas station employee contributes nearly \$259,800.

The restaurant industry is also diverse. Our association is composed of virtually every kind of foodservice company. We have large corporations, and we have an immense base of mom-and-pop mainstreet business operations: In fact, over 70% of the eating and drinking places in America gross less than \$500,000 a year.

Such size and diversity does not foster easy consensus. However, we all agree that the additional out-of-pocket costs and bureaucratic responsibilities of employer mandates will devastate our industry, irrespective of any subsidies offered to low average wage small businesses.

Health care mandates would come on top of numerous other changes Congress has made recently. In the last year alone, Congress has made changes that will squeeze our margins, through a reduction in business meal deductibility and increased tax liability for S-corporations like mine — actions with which this committee has great familiarity.

For most restaurateurs, that cost of the Health Security Act would be enormous.

- For Larry Goldstein, who owns a 250-seat restaurant and deli in Dallas called Bagelstein's, his health care costs under the Clinton plan would increase 52 percent.
- In Jacksonville, Florida, the Famous Amos Restaurants, a nine-unit chain that already pays for 65 percent of its employees' insurance premiums, the Clinton mandate would increase their health care costs by 265 percent.

- In Seattle, Gretchen Mathers, owner of "Gretchen's of Course" will be faced with a whopping 522 percent increase in her current health care costs.
- Godfather's Pizza, based in Omaha, Nebraska, calculates that health care costs will rise 250%.
- Liz Hebson, owner of Hackney's Restaurant in Chicago, says the equivalent of a 7.9% payroll tax would cost her family restaurant chain about \$260,000 each year.

These are not extreme examples. We're seeing them all across the nation. In fact, the examples I just mentioned are restaurateurs who are already providing some insurance for their employees! For the tens of thousands of restaurants that don't provide coverage now because it's just too expensive this will be a brand new expense for them as well as their employees.

Now not every restaurant looks so dire. According to the Clinton proposal, for example, in my own case the initial cost of compliance would pretty much be a wash.

But I don't for a minute accept the premise that I will be unaffected.

For one thing, we don't trust the government's financial forecasts. No prudent businessperson could look at the government's dismal track record in projecting costs in programs like Old-Age Survivors Insurance, Disability Insurance, and the Hospital Insurance portion of Medicare, and think that the White House's projections are going to hold.

For another, the complexity of complying with the employer mandate boggles the mind. I'm giving you a two-page list of the new paperwork rules for employers. Just listen to what we would have to do each month to comply:

- We must, for every employee, calculate the number of hours worked that month and determine our premium -- and this could be different every month for every employee -- remember there are nine million of us.
- We must then determine the percentage of payroll at which our premium payments are capped, which we figure out by calculating the average number of full-time equivalent employees in our business, and the average annual wage per full-time equivalent employee.
- We report whether any employees became newly eligible or ineligible for employer-paid benefits that month. Every time an employee changes eligibility status -- by dropping below 40 hours one month, for example -- we report that to a regional clearinghouse.
- We must receive information from the regional health alliance on something called the "employer collection shortfall add-on," which is surcharge we must pay to make up for funds not collected from other businesses.

And that's just monthly, Mr. Chairman. My point is that this bureaucracy alone will cost us dearly.

The bottom line to all this is jobs.

There is no alternative. America's restaurateurs operate on some of the thinnest profit margins in the business community. They range from three to five percent.

Mr. Chairman, the competition for restaurant business is intense and primarily driven by price. When you add to our costs, with something like this mandated payroll tax for health care, we can't merely take it from profits. Either we raise menu prices, which is at best extremely anti-competitive, or we cut costs in other parts of the business. This inevitably means cutting jobs.

This is no small matter. Let's say every restaurant in America is forced to cut just one job. That alone means hundreds of thousands of jobs lost.

When President Clinton announced his health care plan, he said he had three goals: security, savings and simplicity.

They are great and admirable goals. But those of us in the restaurant industry have to ask the basic questions: Do our employees have more security if restaurants are forced to close or lay off workers?

In terms of savings, when has the federal government -- any government -- performed a major task that actually saved taxpayers all the money that elected officials promised?

Finally, in terms of simplicity, I'll ask you to take a careful look at the two pages of new rules outlined in the legislation. You can only imagine the regulations that would go along with implementing these new rules.

The National Restaurant Association is supporting Congressman Jim Cooper and Congressman Fred Grandy's Managed Competition Act. We believe this bill, with some tinkering around the edges, will bring down health insurance costs to the point where thousands of employers could afford to offer coverage to their workers. Bringing millions of Americans into the system this way without an employer mandate is a far better way to go than sacrificing millions of jobs and the health of American businesses.

Health Care Reform:

Paperwork Under the Clinton Plan

The employer mandate wouldn't just add new costs for employers. It would add tremendous paperwork, too. The Administration's Health Security Act devotes an entire section to new reporting rules for employers. Employers' responsibilities are outlined below.

Paying the employer's share of premiums

- **AT LEAST MONTHLY**, send premium payments to each regional alliance in which your employees are enrolled. To figure what you owe:
 - Calculate the hours each employee worked that month. If they worked 120+ hours, you owe 80% of their premium. If they worked 40-120 hours, you owe a pro-rated share of the 80% premium. (Your share will vary with the exact number of hours worked.) If they worked under 40 hours, you do not owe premiums for that employee that month.
 - Figure in each employee's family status: Premiums vary depending on whether employees are single, married, married with kids, or single with kids.
 - Figure out the percentage of payroll at which your premium payments are capped. Most employers' premium payments are capped at 7.9% of total annual payroll but small, low-wage employers may qualify for rates between 3.5% and 7.1%. To figure out whether you qualify for a lower rate, calculate the average number of full-time equivalent employees in your business, and the average annual wage per full-time equivalent employee.
 - Receive information from the regional health alliance on the "employer collection shortfall add-on." This is a surcharge payable by employers to make up for amounts the regional alliance projects it will fail to collect from other employers.

Deducting workers' premiums from their wages

- **MAKE WAGE DEDUCTIONS, AS APPROPRIATE**, from employees' paychecks to cover their share of the premiums. This will vary with:
 - The type of health plan each employee has chosen.
 - The employee's family status.
 - Whether the employee is low-wage and qualifies for federal subsidies to help pay for premiums.

Complying with other reporting rules

- **EACH JANUARY**, give regional alliances "such information as the alliance may require" to determine how much you should have paid in premiums each month. Calculate whether you overpaid or underpaid during any particular month, and reconcile your payment accordingly.

(over)

**Complying
with other
reporting rules**
(cont.)

- **ONCE A YEAR**, for any employees who qualified for benefits during any month the previous year, tell them what they earned those months, and how much you deducted from their paychecks for their share of the premiums.
- **ON AN ANNUAL BASIS**, report the following to a regional clearinghouse:
 - The number of full-time equivalent employees you employ in each class of enrollment (i.e., single, married, married with kids, or single with kids). Break down information monthly if you receive any kind of premium discount.
 - For each employee who qualified for health benefits, how many months they qualified and into which category they fell (single, married, etc.).
 - Deductions you made from each employee's wages for the employee's share of the premium.
 - What you paid in premiums over the year. If your premiums were capped at a certain percent of payroll, you must calculate the amount you would have owed without the cap.
- **ON A MONTHLY BASIS**, report the following information to a regional clearinghouse:
 - Whether an employee's status changed, making him either eligible or ineligible for health care benefits through the employer.
 - For employees in this category during a particular month, provide the clearinghouse with information about the regional alliance the employee is enrolled in and whether they are single, married, etc.
- **FOR EACH NEW HIRE** who would qualify for employer-paid benefits:
 - Give the employee an enrollment form provided by the regional alliance.
 - Give the employee information on how to choose and enroll in a regional alliance health plan.
 - Within 30 days, send the regional alliance information on the new employee's identity; his alliance area of residence; whether the employee has moved from another alliance area; whether the employee is single, married, etc.; which health plan and health alliance the individual is enrolled in at the time; and whether the individual intends to enroll in a regional alliance health plan.
- **GIVE WRITTEN NOTICE TO INDEPENDENT CONTRACTORS** who perform services for you more than 40 hours a month that you are not required to provide benefits for them.
- **MAINTAIN RECORDS** as may be necessary for verification and audit.

Sources:

Health Security Act, Section 1345, Collections
 Section 1602, Requirement for Information Reporting
 Section 1603, Requirements Relating to New Employees
 Section 1604, Auditing of Records
 Section 1901, Definitions Relating to Employment and Income
 Section 6123, Premium Discounts for Certain Employers

Mr. HOAGLAND. Do you wish to inquire?

Mr. LEVIN. Yes, thank you very much.

This has been helpful testimony. I agree with the point, as we discussed a few weeks ago back home, that there is a difference between part-time and temporary, and I think that is often lost; that we have to, whatever program we have has to be tailored to realities, and there are different realities.

And how we approach where there is an ephemeral connection between the employer and employee is somewhat a different set of issues than where there is a longer, but part-time, term connection.

So let me just begin, if I might, with Mr. Siegel, talk a bit about part-time employees in these stores, OK?

Now, it was hard because your oral testimony was a little different than your written testimony, so I did not jot down all the numbers, but give me the typical picture—or take your own stores. How many of the employees are part-time and how many are full-time?

Mr. SIEGEL. In our company we have about 40 percent full-time and about 60 percent work part-time.

But you have to make a distinction, sir. Most of our part-time employees are part-time because they desire to be part-time. There are a lot of people who are part-time employees who are supplementing other jobs and who could not work for us under a full-time basis.

Mr. LEVIN. That is legitimate. I didn't mean to say that they were part-time involuntarily.

So 60 percent are part-time. Do you know how many of those 60 percent—those 60 percent have no insurance through you; right?

Mr. SIEGEL. That is correct.

Mr. LEVIN. Now, do you know what proportion of the 60 percent are otherwise insured?

Mr. SIEGEL. Approximately, based on facts, and it is in our testimony here and I heard it from Mr. Brennan earlier this morning, I guess supported by statistics, that about 50 percent are probably covered by maybe other programs through their spouse or perhaps as a part-timer for us. They may be a full-time teacher being covered there and their income as a part-timer supplements their full income. I don't have those facts or the statistics.

Mr. LEVIN. You do not have the statistics from within your own company?

Mr. SIEGEL. No, we do not because we have a tremendous amount of turnover. It would be very difficult and these statistics we do not think are particularly important to the issue for us.

Mr. LEVIN. But they really are important to the issue, though, right? Because they represent—

Mr. SIEGEL. A part-timer, let's understand that. Our part-time needs are going to fluctuate based on the season that we are in.

We are a retailer—and if I can get into something, if it is permissible, I can't mandate when a customer comes to my store. They come to my store because I offer a value that they cannot get somewhere else.

I can't mandate that an employee stays working for me rather than going to be employed somewhere else. It is because they enjoy working there and they feel that they have either an opportunity

to grow with the company or that we are providing them certainly with an atmosphere and an opportunity for them to have a better life because they work for us.

I have been married to my wife for 34 years and I cannot mandate she stays with me. I don't like the word. It just does not work. If there is one word—if I could, I have waited here all day today—that I have not heard mentioned here today, that is the word accountability. I think that the provider has to have some accountability.

People come to my store and buy my services or buy my goods because I offer them a value. The provider should be held accountable and we should be able to know what we are paying for.

Also, our employees and the employer must be accountable for their actions. There is not a free ride. Our company did not get started or prosper because something was given to us. We earned it.

Mr. LEVIN. I agree with you 100 percent. My time is up, but let me ask you, as my time expires, what is the average length of employment of part-time people at your company?

Mr. SIEGEL. I would expect that that would be—it just so varies in the different States and different times that we are in, it is hard for me to give you that kind of number.

I would say a part-time employee for us, we have some people that are permanent part-time employees.

If I had to give you a number, I would guess that 50 percent of the part-time employees at least work for us, at varying degrees, 15 to 20 hours at various different times of the year.

But a part-timer for us, what we are including there would also be what you might call a temporary employee who may work for us two or three times a year, 2 or 3 weeks a year.

Mr. LEVIN. Right. OK, thank you very much.

Mr. HOAGLAND. Mrs. Johnson would you like to inquire?

Mrs. JOHNSON. Thank you. And welcome Mr. Colaccino; a pleasure to have you on the panel. It is a pleasure to have someone I personally know as a genuine small businessman who does a tremendous job in Connecticut.

In your testimony, which is very, very helpful, and I am sorry I didn't get a chance to review all your testimony, and since I was not here to hear most of it, I will, and whatever I say to Frank, please, if any of you want to chip in, feel free to.

But I thought it was very enlightening that you would, on the whole, pay less than you are currently paying, or very little more, and other people in your industry are paying very little more under the government's program with 7.9 percent of payroll and yet everybody would be covered. So, clearly, there would be a tremendous cost to government.

Earlier in this hearing there were concerns expressed about whether the government was really willing to come up with the subsidy dollars that their premium structure calls for. Because if they are not, the premiums will go up or we will raise taxes. Well, if Congress has a choice of raising taxes or raising your premiums, you can pretty much guess how that will go.

But if, in fact, you are spending \$5 million roughly now for 1640 employees, and would only have to spend \$5.5 million, \$5.1 versus

\$5.5 million for all 5008 employees, I mean clearly the government is going to bear very significant cost here. It is almost at \$7 million.

So the government will actually be paying more than you will with the 7.5 percent cap.

That ought to be very sobering to those of us who think estimating this matters——

Mr. COLACCINO. No question, and I would say——

Mrs. JOHNSON. Excuse me, just one moment. Let me interrupt you because I want to get to my question, which is actually more important than my comment.

Most people think it is only small businesses that do a lot to educate their employees, to help them not get sick, to help them recover well, all of that preventive work, all of that capital investment and human resources to reduce health care costs and improve health in the broad sense.

And yet you are self-insured and we were talking about your program and what a difference it has made in your cost.

I think it is important for the panel to have on record some of the things small businesses do to help reduce health care costs that you would not be in a position to do if you were simply paying a flat percent of payroll.

Mr. COLACCINO. In our particular situation, what we think is very important is to educate our employees on how to purchase health insurance and how to purchase health care, I should say.

Most of us, when we go to a doctor, we are so—we trust our doctors and our medical people so much that whatever they say, we always do. And in some cases there is unnecessary surgery or unnecessary things that they prescribe that cost all of us more money. And we try to teach our employees how to go out and actually purchase health benefits.

In addition to wellness pay, in addition to sponsoring cholesterol checks at various points throughout the year for our employees, we suggest to our employees that they should get checked up, do more preventive stuff rather than wait for something to happen where there is a crisis.

So because we are self-insured, we manage—I mean we manage very well and we pay attention to the costs of our health insurance.

Mrs. JOHNSON. Your premiums have been what?

Mr. COLACCINO. Our premiums are \$5.1 million——

Mrs. JOHNSON. Have they been flat?

Mr. COLACCINO. For the last couple of years they have been pretty much flat.

Mrs. JOHNSON. I think it is impressive that all of the bills before the Congress, every single one, the President's and everybody's, recognizes that people have to be more educated.

You really have to ask yourself are you going to do a better job than that, or are we going to do a better job and can you do it cheaper?

Look at all the things you enumerated that you are doing for free, basically, that we would have to pay to do. Unfortunately, the red light is on, but I do appreciate your input, and those kinds of examples I urge you to provide to other Members of Congress so they get a better understanding of what the private sector invest-

ment in controlling costs is, and all of that investment would have to be replaced by government expenditures under the President's plan.

Thank you.

Mr. COLACCINO. The point that you made, if I could just mention, at our cost and I think we do a pretty good job at managing health care costs, if we applied our costs to all of our employees, and I just want to reiterate you made that point earlier, it would cost us over \$12 million, yet the 7.9 percent cap from our \$70 million payroll, that amounts to \$5.5 million.

And I can't understand where the difference is, which, really, that is where our skepticism lies, that there is a substantial reduction with putting significantly more people on the plan.

Mr. HOAGLAND. What are your premiums today as a percent of payroll?

Mr. COLACCINO. As a percent of payroll today it is 4.1 percent, the company's portion of our payroll.

Mr. HOAGLAND [presiding]. So you don't cover 80 percent of the premiums then, do you?

Mr. COLEMAN. It is roughly—it ranges between 65 percent the company provides, 35 percent the employees provide.

Mrs. JOHNSON. Actually, the example in the testimony is clearer because they don't cover their part-timers. So the \$5.1 million, that is 4.1 percent, isn't directly comparable to the 7.9 percent. But if they were going to cover everyone, it would cost you instead of \$5.1 million, \$12.6 million; and yet the government would only make them pay \$5.35 for the same, for the government would pick up the difference between \$5.5 and \$12.35, basically \$7 million.

So I am not sure that the President's calculations are taking you into account in that regard.

Mr. COLACCINO. We feel that that is a starting point.

Mr. SIEGEL. If I could make a comment to that. We went into self-funding plan approximately 5 years ago. At that time, we were employing about 1,200 employees. The proposed premium for 1989, proposed premium for those employees under basically the same coverage that we have now would have cost us more than what we are paying now to cover the percentage that we carry now.

There has to be—has to be an incentive both for the employee—we have to control our own destiny. We can't use somebody else in order to take care of us. And I think—one thing that I think needs to be clear here, at least in my mind, is nobody's going to come here and tell you that we are not for universal health care.

It is like being—going back and showing you my age, like being against apple pie, Chevrolet and motherhood. However, if we first control the cost, get the costs under control, and then we can get more people, or hopefully everybody, into the system.

But let's at least know what we are paying for and make sure that we first tackle the real problem, which is health care reform. And then all of us, I think, in every sector, would be willing, knowing that, to be able to help those who, for whatever reason, can't pay their fair share.

Mr. HOAGLAND. Mr. McCrery, would you like to inquire?

Mr. MCCRERY. Thank you, Mr. Chairman, and thank all of you for sticking around today at this late hour. And I commend you for

your testimony, as well, as people who are in the real world and in business, trying to employ folks but also trying to make a profit. You bring a great deal of worthwhile testimony to our committee.

Mr. Siegel, you said that you are now self-insured. Basically, your company is now self-insured, and you said you have to give your employees some incentives to control costs. Can you just briefly recount for us some of those incentives that you built in?

Mr. SIEGEL. Well, maybe the word "incentive" isn't the proper word. The incentive for an employee for us—and again we get into this issue of part-time and full-time; if there is an employee working for us who is part-time, the incentive for them is to do a better job and as more full-time jobs are available, there should be an incentive for it. The incentive that we have is, as we control the costs—and again we have all gone through the process of—I ask any of you or anybody who has gone to a doctor, before you got the care, did you ask how much the bill was going to be?

Well, when the people come into my stores to shop, they see the price they are paying for and they make a judgment whether or not they are getting value for what they are paying. So the incentive is, as we are able to control the costs, we are able to expand on other company benefits.

We just put in this year—from the date a new employee, full-time or part-time, comes to work for us, they get stock options in the company. An employee who has been working for us over 4 years has 3 weeks' paid vacation time. We want to have an incentive for an employee to be a good employee. If they do a good job and contribute to the company, then there are other benefits that are as important certainly as health care. And so the incentive is to move up in our company.

As our company grows, we have been able to take minimum-wage, part-time employees who now are managers of our stores.

Mr. MCCRERY. But how do you encourage your employees to control the health care costs so they can share in the other benefits?

Mr. SIEGEL. Education, a lot of the other things that were said here. Because our human resources department is involved in changing, we just went to a three-option plan based on different deductibles. As we have become more a part of the system, we have been able to educate our employees and assist those employees who, for whatever reason—our part-time employees to be able to find their own insurance if it is needed or maybe go back to their spouse's program and challenge that system.

But it is an education program, preemptive care.

Mr. ELMONT. We provide economic incentives for our employees. For example, if they go to the emergency room with a common cold, they have a \$500 deductible. If they go to their doctor on a scheduled visit for a common cold, it costs them \$10. So we build into our insurance plan very high economic rewards for employees who use the system with prudence and very high economic penalties for those who choose not to be prudent.

Mr. MCCRERY. And Mr. Siegel does the same thing in a different way. He gives his employees an economic incentive to be prudent consumers of health care. And therein lies, I think, the answer to—or at least the biggest part of the answer for cost controls in the health care system, giving individual consumers an economic incen-

tive to control the costs themselves—in effect, to ration their own care, rather than top-down bureaucratic rationing which is the result of the Clinton plan.

Thank you.

Mr. HOAGLAND. Mr. Santorum.

Mr. SANTORUM. Thank you, Mr. Chairman. It is a very appropriate lead-in, Jim, to a discussion of medical savings accounts. And I saw from Mr. Siegel's testimony that IMRA has endorsed the medical savings account as an appropriate mechanism for cost control.

I would be curious as to how other members of the panel feel about that concept, if anybody has any comments or knows of it.

Mr. LENZ. Well, we know of them in concept, and I think those kinds of voluntary programs would certainly be the kinds of things our members would be interested in seeing Congress adopt.

We haven't focused on it in detail and we haven't endorsed any specific plan yet, but that certainly is one of the ones that we talk to our members about.

Mr. ELMONT. Anything that is going to provide accountability of the individual user is one of the things that is going to dramatically impact the cost of health care in America. So we, as business people, are absolutely for individual accountability, and a savings account will do that.

Mr. SANTORUM. Thank you, Mr. Elmont.

One of the things we have just been hearing is the need for education. And sitting back, at least my perception of human nature is that people do things if they have an economic incentive to do things. And they don't if someone else is doing things for them. I remember when I went to school when I was younger and going to college, I had just got out of high school and education wasn't that important to me, because I didn't realize the direct impact it had on my earning capacity.

I got out of school and worked a few years and went back to school, and I recognized at that point in time how valuable this education was because it, in fact, meant something to me as far as something as tangible as my economic well-being. And I did a lot better, I paid a lot more attention. And I think what you find is a lot of students who go back to school these days, after having been out and having experienced the real world, they learn a lot more.

I think really the same lesson applies here, that once people feel that there is something at stake, that they have something at risk here, or they can have an opportunity to benefit economically from education, then in fact that will be the greatest motivator to get people to be smart consumers.

And so I compliment Mr. Siegel and Mr. Elmont and others who support that. For those of you who are not familiar, I will recommend to you any of the Republican plans which have medical savings account as a component of it. Thank you.

Mr. HOAGLAND. OK.

Mr. Herger, would you like to inquire? No?

I just have two questions.

First, Mr. Hartwig, in your testimony you suggested that one way of putting together an employer mandate that would be ac-

ceptable to the temporary—and workable in the temporary help industry, would be a FICA-type payroll tax related to wages paid on employers with temporary employees. How would that work?

Mr. HARTWIG. Well, I suspect it would work very much the way the FICA tax does now; namely, that there would be a certain percentage assessed for actual wages paid which would be the funding mechanism for the health care coverage that would be provided for the temporary employee, who is with us for a very short period of time, may work for another temporary employer for an equally short period of time, or go to work for a full-time employer at some point during the year.

In other words, the relationship is so fluctuating and so volatile, that it really becomes extraordinarily difficult from an administrative standpoint, as well as from a payment mechanism standpoint, to try to design funding for the mandate in any other way, in our view.

Mr. HOAGLAND. Mr. Elmont, I notice that you indicated the National Restaurant Association supports the Cooper bill?

Mr. ELMONT. Yes, sir.

Mr. HOAGLAND. Now, some information we have is that the Cooper bill would leave as many as 25 million Americans without health insurance.

Now, my question is, it doesn't deal so much with that, but with the feasibility of using—of requiring insurance companies to community-rate and to insure anyone that walks in the door with policies that people can take from job to job and place to place. If we can't include everybody in the system for community-rating purposes—do you track?

Mr. ELMONT. I am sorry, your question was what?

Mr. HOAGLAND. Well, my question is, the community-raters that the insurance—the actuaries at the insurance companies tell us that if everyone in America is not included in a system, why then it is going to be impossible to community-rate. It is going to be—it is going to be impossible to require that the insurance companies issue policies to everyone who applies, and that basically we are not going to be able to solve the affordability problem without bringing everybody into the system, which presumably is why the Clintons have mandates in their plan.

Mr. ELMONT. Well, what concerns me is 85 percent of all Americans are covered by insurance now. And to take something that is consuming 13 percent of the Gross Domestic Product to insure 15 percent of Americans, I think we have overkill. So the Cooper bill tries to bring more people into the system.

Whether the shortfall will be 10 million or 25 million or 5 million, I think it is a much more prudent approach in the short term to ensure the long-term health of the economy. So that is why business people like the National Restaurant Association and the Business Roundtable are supporting the Cooper bill. It has issues that we would like to modify, like anything else, but it is a far more prudent approach than President Clinton's plan.

Mr. HOAGLAND. And it is your view that the employer mandate would create lots and lots of disruptions that would not make the gains worth it?

Mr. ELMONT. Well, if one looks at our industry where 70 percent of all of our members have grosses under half a million dollars, which means that only 23 percent of those employers currently provide insurance, that is an awesome shortfall. So that means you have approximately 75 percent of businesses with under half a million dollars in our industry that would have employer mandates. Forgetting, of course, that the 9 million employees in our industry, many of whom aren't cognizant of the fact that they would be paying 20 percent of the premium, they don't have the money, they don't want to do it—the part-time workers like Mr. Siegel's, who want different options.

Mr. HOAGLAND. But my question is, can we successfully have insurance reform without bringing all Americans into the system?

Mr. ELMONT. I believe we can.

Mr. HOAGLAND. And you think the Cooper bill will pull enough in to make it workable?

Mr. ELMONT. My hope is that it will, it will get bipartisan support and it will work.

Mr. HOAGLAND. OK. Well, thank you for coming, gentlemen, I appreciate—it appears that no one else has any questions, so we will end the panel and end the hearing for today. And thanks to all of you for having attended.

[Whereupon, at 5:23 p.m., the committee was adjourned.]

[Submissions for the record follow:]

Written Statement of the American Automobile Manufacturers Association
for the record of:
Committee on Ways and Means
Hearing of February 3, 1994
on H.R. 3600, the Administration's Health Security Act

The American Automobile Manufacturers Association represents America's Car Companies -- Chrysler, Ford, and General Motors. These companies pay nearly \$6 billion a year in health costs, excluding reserves for future retiree health liability. They provide comprehensive health coverage for 2.8 million people -- one out of every 90 Americans.

AAMA's member companies strongly support comprehensive health reform that provides universal health insurance coverage financed in an equitable manner. If the nation chooses to enact reforms that build on our employer-based health insurance system, then all employers must contribute to the cost of covering their active workers and non-working dependents.

Without the participation of all employers, the nation will continue to have significant numbers of uninsured workers, and the resulting cost-shifting between firms and sectors of the economy will produce subsidies for some at the expense of others. Our current "voluntary system" allows some firms and individuals to voluntarily avoid paying for coverage, while others who pay for coverage must involuntarily bear the costs of care rendered to the uninsured.

Requiring the participation of all employers will significantly reduce the number of uninsured. According to the Employee Benefit Research Institute, the number of uninsured increased to 38.5 million in 1992, but 84 percent of the uninsured lived in families headed by workers. These uninsured families currently represent a significant cost to firms that provide coverage as a result of cost-shifting.

A study by Lewin/ICF for the National Association of Manufacturers examined the extent and sources of cost-shifting to manufacturing firms. The total cost-shift burden paid by manufacturers in 1991 was \$11.5 billion, representing 28 percent of their total health costs. The largest component of this shifted burden, amounting to \$7.2 billion or 63 percent of the total, was related to working dependents who did not receive coverage from their own employer but were covered by a manufacturer's health plan.

Voluntary Efforts to Expand Coverage

Some reform plans would rely on voluntary incentives to achieve expanded coverage, but the results of various state initiatives and demonstration projects are not encouraging. David Helms, President of the Alpha Center, in testimony before the Senate Finance Committee on February 1, reviewed the results of eleven demonstration projects and numerous state initiatives using voluntary incentives to make insurance more available and affordable for non-insuring firms. These incentives included substantial premium subsidies (some as large as 50 percent to 75 percent below market rates), tax credits, limited benefit plans, and buying cooperatives.

Results measured by enrollment in plans and market penetration were poor, causing Helms to determine, "there is little evidence that voluntary efforts alone will close the gap on the uninsured problem." His conclusion was "that effective cost control, either through managed competition or more explicit expenditure limits, requires a system of universal coverage without free riders."

At the same Senate Finance Committee hearing, representatives of the major insurance groups testified that insurance reform alone cannot achieve universal access, and that mandatory coverage will be necessary.

Under the existing voluntary system, the uninsured population is increasing steadily. The following figures from the Employee Benefit Research Institute show the growth in the uninsured population from 1988 to 1992:

<u>Year</u>	<u>Uninsured</u>	<u>% of Non-Elderly Population</u>
1988	33.6 million	(15.9%)
1989	34.4 million	(16.1%)
1990	35.7 million	(16.5%)
1991	36.3 million	(16.6%)
1992	38.5 million	(17.4%)

EBRI's report of January, 1994 on the characteristics of the uninsured stated: "A primary reason for the increase in the number of uninsured between 1991 and 1992 was a decline in employment-based coverage among individuals (and their families) working for small firms."

Thus, we know that the current voluntary system is covering a smaller percentage of our population each year, and that an array of voluntary incentives will not achieve the goal of universal coverage. What do we know about the effects of a mandatory employer-based system supplemented by special incentives and subsidies for small businesses and firms with many low-wage workers?

Effects of Mandatory Coverage

The only state requiring employer contributions for employee health insurance, Hawaii, has achieved near universal coverage with minimal economic disruption. When Hawaii enacted its Prepaid Health Care Act in 1974, 17 percent of its population was uninsured. Now, with broad coverage and an emphasis on preventive services and early treatment, Hawaii's health care costs are 8.1 percent of GDP versus nearly 14 percent for the U.S. generally. And this has been accomplished in a state where over 90 percent of the firms employ 50 people or less.

Also instructive are the evaluations of the Administration's proposal by the Congressional Budget Office and the Council of Economic Advisors. Both acknowledge that firms with low-wage workers would be affected, but conclude there would be relatively small impact on net low-wage employment.

Firms which would experience higher costs as a result of mandatory coverage have a number of options. They can increase prices to consumers, decrease dividends to investors, restrain the take-home pay of employees, or a combination of these. According to CBO, even if the employer is required to pay most of the health premiums, the actual incidence will be largely borne by employees, "because most workers continue to work even if their take-home pay declines."

The Hawaii experience of 10 years, and the CBO analysis of the Administration proposal demonstrate that a mandatory system, with a well-designed set of subsidies for firms with low income workers, can achieve universal coverage without producing great economic disruption. The beneficial effects of such a system include an end to cost-shifting and more equitable financing of health coverage.

Inadequacy of Individual Mandates Alone

A reformed system must have a reliable, adequate, and administratively efficient financing system. The appropriate number of dollars must flow to the public and private health plans which deliver health services to individuals. A tax-financed system, or an employer-based system which relies on employers to submit payments on behalf of their covered populations, can accomplish this task. A system that relies on individuals to make monthly payments cannot.

The costs of administering an individual mandate, with millions of payers, will be high, and the level of non-compliance will be substantial. Experience shows that many individuals will avoid paying for coverage, and others will do so sporadically. In states with mandatory automobile insurance, for example, the number of uninsured motorists is uncomfortably high. Under an individual mandate, the subsidies for low-income people would have to be channeled through the tax system. Since many low-income individuals do not file tax returns, including many who are eligible for the earned-income tax credit, we see no existing proposal that would induce these individuals to buy coverage, even if it were subsidized.

Equitable Reforms

A voluntary system, with free riders, can never be organized in an equitable manner. Coverage for everyone must be explicitly financed so that we can end cost-shifting. Mandatory coverage is required if we are to spread the financial risks of poor health as broadly as possible to achieve the lowest community rates. We all have to be in this together.

The current voluntary system, if allowed to continue on its current path, will follow a destructive spiral of greater numbers of uninsured, with increasing costs shifted to those firms which continue to provide coverage. Some firms faced with increasing costs will reduce or drop coverage and the downward spiral will continue. The cost-shift burden, which increases total health costs of U.S. manufacturers by 28 percent, is unacceptable and unsustainable at a time when U.S. firms must compete against global competitors whose governments provide health coverage for their workers and retirees.

Public support for mandatory employer contributions remains high. An ABC/Washington Post poll released on February 10 showed that 74 percent support a federal law requiring employer mandates, while 24 percent are opposed.

AAMA's member companies strongly support a requirement that all employers make a financial contribution to the cost of coverage for their active workers and their non-working dependents. This is an essential element in reform of our employer-based health care system to achieve universal coverage.

STATEMENT OF THE AMERICAN HOTEL & MOTEL ASSOCIATION

The American Hotel & Motel Association is a federation of associations representing lodging's interests in the 50 states, the District of Columbia, Puerto Rico and the Virgin Islands. The Association federation has a membership in excess of 10,000 individual lodging properties which represents approximately 1.3 million rooms. Inclusive in our membership are all of the major hotel and motel chains and a large percentage of independent properties.

The entire industry is made up of approximately 45,000 hotels employing over 1.5 million people to serve over 3 million guest rooms. Unfortunately, the image one tends to get about the hotel/motel industry is distorted by the large convention hotels in our major cities and the mega destinations such as Las Vegas and Orlando. One is left with the impression that ours is an industry dominated by large hotels. Nothing could be further from the truth. Just over two-thirds of our country's hotels have under 75 rooms with likely employment between 25 and 50 employees. Typically a company will operate more than one hotel property and thus will have total employment of over 75 individuals, the subsidy cut-off point under the Clinton health plan. But whether we fall below or go over 75 employees, we are truly an industry of small businesses, and it is principally on behalf of that segment of our industry that we address our comments.

We take pride in our industry's job creation and career starting history, but must point out that being a source of entry-level jobs bears extra costs. Frequently we give an individual his or her first job and just as frequently we are one of only a few service industry employers who will do so. In addition to teaching our new employees the skills necessary for the particular job, we must train them about general job skills such as punctuality, attendance, task completion and the like. Conducting this informal training requires extra management supervision as well as accepting lower productivity from the new employee. When our industry's high turnover rate for hourly employees is factored in, it becomes clear that there is permanent lower productivity for many, if not most, of our hourly positions. This results in lower wages and initial compensation at or near the minimum wage in many parts of the country. It also results in a more restrictive benefits package, including restrictions in the provision of healthcare benefits. This is particularly true for part-time employees.

Because of its position in the service sector and as an engine of job creation, the membership of AH&MA has concerns about healthcare. These concerns operate on two levels. On the first, broader level, we agree that there are problems with our nation's healthcare system that need to be addressed. We also agree with those people who have publicly stated that our nation's problems, while serious, fall short of a "crisis." We believe that issues that need to be addressed by the Congress include:

- market-based methods to control excessive and growing cost of healthcare which typically exceeds inflation;
- universal access to healthcare for citizens and legal residents without limitation due to pre-existing conditions, change in employment or similar occurrence;
- allowing small businesses to join together for better buying power of insurance coverage;
- administrative reforms to reduce the costly burden of excessive paperwork; and
- legal reforms to combat fraud and reduce the costs of defensive medicine.

There seems to be little disagreement that all of the above reforms need to be done and, in fact, either as a freestanding bill or as part of more comprehensive attempts to reform healthcare, virtually all healthcare bills in Congress address these topics. However, there seems to be little else in any of these healthcare bills that is supported by a majority or even close to a majority of the House of Representatives or the Senate. While forces are fighting for agreement on approaches ranging from single payer to various versions of managed competition, these basic areas of agreement lie waiting for enactment. With so much at risk and so many wise people of good will from all parts of the political spectrum in disagreement about the more controversial and questionable areas of reform, we strongly urge this Committee to move forward on those areas of reform on which there is a broad consensus, while continuing its work to reach agreement on other areas of healthcare reform.

On the second and narrower level of our concern, we view with distinct alarm the goal of the Administration's healthcare reform package to force all employers to provide insurance to all employees and pay 80 percent of its cost. The American economy is as diverse as it is broad and this "one-size-fits-all" approach to healthcare coverage will reward one

segment of our economy while punishing another. This employer mandate simply can not be applied to the lodging industry without causing substantial disruption in our operations and job creation ability. In fact, employer mandates will force job reductions in our industry.

As we said earlier in this testimony, we are one of the few industries that has a strong record of job creation for first time employees. We find it disheartening and frustrating to the point of anger to find our jobs disparaged by the Administration in favor of high tech, high wage jobs in fast growing industries. All of us may wish that every American could qualify for a high tech job, but the truth is all of us can't. Honest labor in any industry should be respected as should the people who hold these jobs. The fact that the economic value of jobs differ and the salary and benefits attributed to jobs also differ should not be used to disparage our first time employees or those of any other segment of the service industry.

Unfortunately this seems not to be the case. When we argue that our industry's response to burdensome governmental action which increases the cost of labor far beyond its economic value will be a forced reduction in jobs, or a limitation on our job creating ability, this fact is typically ignored by many in the Congress and Administration. Even worse, this result is occasionally viewed somewhat favorably because the jobs we create are looked upon with disdain.

Despite the seeming bias against our industry and its employees, we will persist in making our argument, this time focusing on the employer mandate. Recently a survey of our industry examining the nature and extent of healthcare coverage was conducted. Over 4,000 properties participated in providing information. The results were tabulated by Smith Travel Research, a respected information source in the travel and tourism industry. The information showed that there is a significant number of smaller properties unable to provide healthcare coverage in our industry. As stated above, there are a number of constraints and financial pressures on these properties which make the provision of health insurance impossible. We should note, by comparison, that virtually every company large enough to do so offers and shares the cost of healthcare benefits for its full-time employees, although the nature and extent of this coverage varies greatly in our industry.

Of interest is the fact that when the opportunity is presented, many employees do not choose to take health coverage. This occurs for a combination of reasons including personal coverage from another job, spousal or dependent coverage, or the need to maximize earnings. Whatever the reason, many employees with health insurance in our industry have chosen not to have coverage. We have always respected that choice and not forced an employee to take healthcare coverage. In that we believe our industry is not unique; we know of no industry which forces healthcare coverage on its employees. However, well over one-third of our smaller properties are without healthcare coverage and will be impacted most negatively by an employer mandate. As debate over healthcare has progressed, it has become an accepted fact that where a company has a workforce which is near or at the minimum wage, that company will bear the full brunt of an employer mandate—there is no possible passing on of costs to employees through wage restrictions over time. For those employers, choices are limited. The obvious choice, to raise prices, does not exist for many of our smaller operators due to the competitive environment they find themselves in. Of the choices left, some will go out of business, ceding their market share to large hotel properties in the area; most will limit job growth or eliminate jobs. Accurate predictions of job losses are difficult to make, but Smith Travel Research anticipates that 50,000 to 100,000 jobs may be lost due to employer mandates. This will not be spread uniformly across our industry but will be concentrated in the smaller property segment. The result for these properties will be just the reverse of that expected by the Administration. These employers will not be providing insurance to all their current employees. Instead they will be eliminating jobs. What makes this outcome even more regrettable is that the Administration expects to "solve" the welfare problem next and one of its solutions is to have the private sector employ many of those currently on welfare. Our industry is undoubtedly one of those that the Administration will look to to increase hiring. Unfortunately, they will be somewhat late, since healthcare will have foreclosed a large part of our job creating ability, at least in the short run. But even if we don't look that far ahead, we can not ignore the current reality that jobs and job opportunities will be foreclosed if an employer mandate is imposed.

We call upon this Committee to continue its efforts to find workable solutions to our nation's healthcare problems, but to abandon, as a funding mechanism, the employer mandate.

**STATEMENT OF
THE AMERICAN LUNG ASSOCIATION
AND
THE AMERICAN THORACIC SOCIETY**

These comments are submitted on behalf of the American Lung Association and its medical section, the American Thoracic Society.

Founded in 1904 to fight tuberculosis, the American Lung Association is the oldest nationwide voluntary health agency in the United States. Along with its medical section, the American Thoracic Society — a 10,000 member professional organization of physicians, scientists, and other health professionals specializing in pulmonary medicine and lung research — the American Lung Association provides programs of education, community services, advocacy and research to fight lung disease and promote lung health.

Every year, nearly 310,000 Americans die of lung disease. Lung disease is now America's number three killer, responsible for one in seven deaths. That rank will likely change. The lung disease death rate is climbing steeply, while the rates for America's first-and second-ranked causes of death, heart disease and cancer (except for lung cancer), are dropping. From 1979 to 1990, the lung-disease death rate rose by 20.6 percent, while the death rate from heart disease fell a dramatic 23.8 percent.

A little over three years ago, and in part because of these grim statistics, the ALA/ATS began deliberating the issue of health care reform, looking at the issue from the unique perspective of the needs of people with chronic lung disease. In 1992, we formalized our thoughts in a policy statement that was approved by the respective Boards of Directors of the two organizations. A copy of our policy statement is included with this testimony. We support guaranteed coverage that prohibits any pre-existing condition exemption. The coverage must be portable and affordable as well. Our statement also specifically endorses continuation of an employer-based system that mandates employer participation with mechanisms to facilitate that participation.

EMPLOYER MANDATE

The ALA/ATS believes any new health care system should be built upon our current public/private system. We support an employer-mandated system in which mechanisms and incentives are established to help employers finance health care benefits for their employees and the employees' dependents. We believe this would be the least disruptive way to achieve universal coverage, another tenet of our position. Our statement also proposes a list of benefits the ALA/ATS believes must, at a minimum, be included in the employed financed package. Employers should certainly be free to offer benefits above and beyond those mandated. Individuals also should be allowed to purchase supplemental coverage on their own if they so choose.

In the past forty years, Americans have come to rely on their employer as the provider of health insurance. While the Clinton plan does not mandate that the employer choose the one or two plans to be offered to their employees, it does require the employer to serve as the chief or primary contact for the employee to deal with the overwhelming and daunting health insurance system. Workers already are comfortable with that arrangement. The role of the employer certainly changes under the Clinton plan from that of benefits administrator, to more of a facilitator of information. It appears this would be a less time-consuming and less costly role for the employer, while retaining the current relationship with the employee. Individuals who are uncomfortable obtaining health insurance through their employer have the option to work directly with the regional health alliance.

An employer mandate would level the playing field among different employers, most of whom provide such coverage today. And it would eliminate large, unpredictable and unequitable cost shifts that employers bear today for the uninsured workers of other employers, as well as the more subtle cost-shift that all payers of health service encounter due to inadequate Medicare and Medicaid payments. According to a 1991 Lewin/ICF study on cost-shifting, if all forms of cost-shifting were eliminated, employer health costs could be reduced by approximately 10 percent.

The ALA/ATS does not believe that the health care system should be financed totally by either the government or the private sector. But rather, the current sharing of responsibility is the appropriate way to proceed. We realize that some employers and individuals will need financial help to meet their obligation. Therefore, the proposal for employers to finance partial coverage, with assistance from the government, is ideal. This arrangement does not preclude individual responsibility for paying for a part of his or her health care costs, again with governmental assistance if necessary.

BENEFITS PACKAGE

Our statement also provides details of what we believe a standard benefits package should look like, giving examples of pulmonary-specific benefits. A chart detailing that discussion is located on page 3 of our attached policy statement. The ALA/ATS presented testimony on this aspect of health system reform at the November 15, 1993, hearing of the Health Subcommittee.

The ALA/ATS supports a uniform package of basic benefits that includes the appropriate levels of preventive, acute, chronic, and rehabilitative care. Although we do not specifically include long-term care benefits in our position paper, we also would support the inclusion of long-term care benefits in a basic package.

INSURANCE REFORMS

The ALA/ATS supports the need for changes in our current health insurance industry to ensure universal health care coverage. Most of these changes are included in the Clinton and other proposals. Primarily, all pre-existing condition clauses or mandated waiting periods must be eliminated. For people with chronic conditions, even a six-month delay in coverage could be catastrophic. If the particular treatment is expensive, the person may become bankrupt in the intervening time, or forego the expensive treatment, thereby increasing the severity of their condition -- and in all likelihood the ultimate cost of treating their illness -- for when they do become eligible for coverage.

The ALA/ATS believes that coverage must be guaranteed renewable and that coverage should not be cancelled for any reason, including nonpayment of premiums. Although every effort should be made to ensure that individuals who can afford to pay for their treatment do so, inability to pay for care must not be the deciding factor in care delivery.

Community rating must also be ensured. People who are sick must have access to the health care system. Charging them more to receive the benefits they need -- which, in fact, the current premium system does -- is inherently wrong. This approach must be changed to a system that treats everyone equally. Many diseases, conditions, or injuries are unavoidable and people should not be penalized for becoming ill or disabled.

The ALA/ATS also supports the consolidation of the medical portion of the worker's compensation plan into the new system. This program has created jurisdictional problems from both an insurance perspective and a health care management perspective; we welcome the president's proposal in this area.

CONSOLIDATION OF FEDERAL HEALTH PROGRAMS

The ALA/ATS supports the president's proposal to consolidate the Federal Employees Health Benefits program and the Medicaid program into the new system. We also support the consolidation of all other federally funded health programs into a single entity. We would include in this consolidation programs currently funded through the Veterans Administration, the Department of Defense, the Indian Health Service, the migrant health centers, and so forth. We believe this would eliminate costly duplication of physical structures, equipment purchases, and personnel. This consolidation would also stream-line government functions. Instead of having multiple rules, regulations, and procedures -- not to mention forms -- one single procedure could be used by all federal health systems.

SUMMARY

In summary, the ALA/ATS supports a mandate on employers to help finance health care benefits for their employees and the employees' dependents. The system must include mechanisms that allow and ensure compliance with this mandate. The benefits provided by the employer must be comprehensive and uniform for all individuals, with the option for either the employer or the employee to purchase supplemental benefits. The ALA/ATS also supports changes to the current system to eliminate cherry picking and other cost avoidance mechanisms used by the health insurance industry. The ALA/ATS also supports the consolidation of all federal health programs into one single entity.

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AMERICAN
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**Position Statement
of the
ALA/ATS Health Care Policy Task
Force**

**REFORM OF THE U.S. HEALTH
CARE SYSTEM**

**Prepared by the American Lung Association
and its medical section,
the American Thoracic Society**

**When You Can't
Breathe,
Nothing Else
Matters®**

Founded in 1904, the American Lung Association includes affiliated associations throughout the U.S., and a medical section, the American Thoracic Society.

Official Journals

American Review of
Respiratory Disease

American Journal of
Respiratory Cell and
Molecular Biology

**Adopted by
ATS Board of Directors
November 13, 1992**

**Adopted by
ALA Board of Directors
December 12, 1992**

**Position Statement
of the
ALA/ATS Health Care Policy Task Force**

**REFORM OF THE U.S. HEALTH
CARE SYSTEM**

Founded in 1904 to fight tuberculosis, the American Lung Association is the oldest nationwide voluntary health agency in the United States. Along with its medical section, the American Thoracic Society -- a 10,000 member professional organization of physicians, scientists, and other health professionals specializing in pulmonary medicine and lung research -- the Lung Association provides programs of education, community service, advocacy and research to fight lung disease and promote lung health.

Based on this mission, we believe our health care system must meet the multiple needs of people with lung disease. It is widely recognized that far too many people are without access to even the most basic of health care services in our current health care system. This structure, therefore, does not meet the needs of people with lung disease or other diseases existing in our society today.

A strong national medical research agenda as well as an effective medical education program are critical to our health care system. However, after considerable discussion, the Task Force agreed that this document was not the proper place to consider these significant yet slightly tangential issues.

The ALA/ATS believes that patients (consumers of health care) and deliverers of health care must have an effective voice in the health care reform debate. As advocates for persons with lung disease and representing people who deliver health care, we therefore call on Congress and the federal government to enact comprehensive health reform that takes into account the principles outlined in this document. We recognize the complexity involved in these proposed changes and the need for a structure to represent the diverse constituencies to implement the changes.

ALA/ATS POSITION STATEMENT ON HEALTH CARE POLICY

The ALA/ATS supports the development of a health care system that will meet the special needs of patients with lung disease based on the following criteria:

ELIGIBILITY

ALA/ATS POSITION: *Health care is a right. Our health care system(s) must guarantee access to a basic level of services for all residents of the United States regardless of employment status, ability to pay, pre-existing condition or other factors such as, but not limited to, age, gender, sexual orientation, or racial or ethnic background.*

We believe health care is a right to which individuals are entitled by virtue of their existence. We recognize and separate this right from those rights that are guaranteed through the Constitution of the United States and the legal system of the United States. Residents of this nation must not be excluded from the health care system for any reason.

Although we believe all U.S. residents must have access to the health care system, we recognize that parameters must be set with regard to the breadth of services provided. For that reason, we support a basic level of health care services to which all residents are entitled. Unfortunately, the United States simply does not have the resources to guarantee unlimited health care coverage to all individuals.

COVERAGE AND BENEFITS

ALA/ATS POSITION: *Comprehensiveness — The basic level of services must be the same for all individuals. These services include appropriate levels of preventive, acute, chronic, and rehabilitative care, and must be provided so as to preserve continuity of care. Access to these services must continue regardless of the cause of illness, or an individual's employment, physical, mental, geographic, or financial state.*

ALA/ATS POSITION: *Quality of Care — The basic level of services should be effective, appropriate, and timely. Medical effectiveness is defined by research findings. Appropriateness is determined by the patient, the family, and the health care team. Timely means without delays that would otherwise adversely affect the outcomes of care.*

ALA/ATS POSITION: *Basic Level of Services — These services should be broad-based and the same for all individuals. Services to be provided are listed on the following page.*

BASIC HEALTH CARE SERVICES TO BE PROVIDED

	<u>Basic Health Services</u>	<u>Pulmonary-Specific Examples</u>
Preventive	Prenatal care Well baby/well child Family planning services Childhood immunizations Adult immunizations Education Periodic health examinations Effective therapies for at-risk populations	TB skin test Appropriate testing for congenital processes (cystic fibrosis, alpha-1 antitrypsin deficiency) TB prophylaxis Influenza, pneumococcal vaccine Smoking cessation programs Pentamidine aerosol (HIV) Screening for occupation- and environment-related pulmonary problems Routine and complaint-specific clinical evaluations
Outpatient	Diagnostic evaluation: history, physical examination, testing, procedures, chronic therapy Prescription drugs	Diagnostic evaluation: routine physical problem-directed history, physical examination Diagnostic testing: radiologic imaging, pulmonary functions Outpatient procedures: thoracentesis, fiberoptic bronchoscopy Ongoing treatment for chronic problems: chronic obstructive pulmonary disease – COPD (chronic bronchitis, emphysema), cystic fibrosis, sarcoidosis, asthma, occupational lung diseases
Inpatient	Extensive diagnostic evaluation Complex treatment of both acute and chronic conditions	Follow-up for positive findings on diagnostic evaluation Treatment for serious exacerbation of chronic problem(s): COPD Treatment for serious exacerbation of acute problems: pneumonia
Rehabilitation	Physical therapy Occupational therapy Supportive care: nursing facilities, home care, durable medical equipment, respite, hospice Mental health services: substance abuse	Physical therapy Occupational therapy Respiratory therapy Pulmonary rehabilitation Supportive care: home care, chronic ventilator care, oxygen

STRUCTURE

We believe all societal barriers must be eliminated, including jurisdictional questions over coverage, so all individuals have access to the same, uniform set of services and that these services are portable. The guaranteed services should span the continuum of coverage from preventive health services including prenatal and pregnancy care, immunizations, and health screenings to acute services including inpatient hospital care and outpatient services, and chronic and rehabilitative care. In all cases, the services provided must be medically effective as defined through research findings; appropriate as determined by the patient, family and health care team; and timely – without delay due to financial or administrative barriers. We also realize that there are societal interests that may be affected in the provision of care.

***ALA/ATS POSITION:** We favor a health care system that is a pluralistic public/private payment and delivery system. Mechanisms must be established to facilitate the requirement of employers to finance the health care benefits of their employees and employees' dependents. Supplemental benefits can be provided in whole or in part by the employer, or purchased privately by the individual.*

We recommend that all federally-sponsored health care programs be consolidated into a single public plan.

We believe the new health care system should build upon our current public/private system. We support an employer mandated system in which mechanisms and incentives would be established to help employers finance health care benefits for their employees and the employees' dependents. Under this proposal, the employer could, for example, provide health care benefits directly as a self-insured program or purchase a group plan as long as the benefits financed by the employer include at a minimum all the services listed in the Benefits section on page 3. Employers would certainly be free to offer benefits above and beyond those mandated. Individuals also would be allowed to purchase supplemental coverage on their own, if they so choose.

It may also be necessary to effect changes at the federal government level with respect to small market insurance laws (i.e., guaranteed issue, guaranteed renewability, community ratings) to facilitate employer compliance. In addition, procedures must be in place to ensure that health care services are provided in instances of jurisdictional coverage dispute (e.g., workers' compensation versus traditional insurance).

We strongly believe that all federally-sponsored health care programs should be consolidated into a single public plan that provides all the services listed in the Benefits section on page 3. This plan would include

SYSTEMIC AND PROVIDER CONCERNS

the Medicare program, Medicaid, Veterans' Administration health programs, CHAMPUS, community and migrant health programs, and so on. It would eliminate the duplications of administration and delivery of services among these many programs. It also would allow for a uniform public program that would not vary by state (as is the problem with Medicaid), and allow access to services regardless of the nature of the illness (as with the VA programs).

ALA/ATS POSITION: *Administrative* — *The administration of the health care system must facilitate patient access to care. The administrative process of the health care system must be standardized for all payers, thus maximizing resources for actual health care services.*

ALA/ATS POSITION: *Provider Reimbursement and Availability* — *Providers must be fairly compensated to ensure access to health care. This compensation should reflect provider cost, work, and time. Incentives must be developed to encourage an appropriate distribution between primary care and specialty physicians and a more equitable distribution of health care providers to ensure access to care in rural, inner city, or otherwise underserved areas.*

We believe the system must be "user friendly" and easily accessible to patients. We believe the administrative processes of the health care system must be simplified and standardized for all payers so that more of our health care dollars are spent in providing health care services, and less for paying salaries of people hired to fill out forms. Reforms in this area could include electronic filing of claims, a single uniform insurance form, or "smart cards" for individuals.

We also believe all providers of health care (physicians, nurses, nurse practitioners, clinical nurse specialists, physician assistants, allied health professionals, and hospitals) should be reimbursed at a fair rate so as to ensure full access for patients to all providers. We also believe incentives must be created within the medical education system to ensure the availability of a full range of providers in all geographic regions, especially in areas that are traditionally underserved. A strong primary care network must be developed to act as the entrance point for individuals into the health care system.

To achieve these goals, we make the following recommendations: improve academic preparation in middle and high schools; provide financial incentives such as scholarships, loan forgiveness or tax credits; revise clinical curricula in medical school to emphasize ambulatory care; equalize compensation between primary care and medical specialties; and reform the malpractice insurance system.

INDIVIDUAL AND PUBLIC RESPONSIBILITIES

ALA/ATS POSITION: *Education for health is the responsibility of many sectors of society including employers, schools, families, religious institutions, health providers and voluntary health agencies such as the American Lung Association, the American Thoracic Society, and others. Individual responsibility for health is crucial to an effective health care system. Through proper education individuals will become empowered, active, and aware of their responsibility for positive health behavior and maintenance of healthy life styles.*

We believe strong, comprehensive health education programs are an integral part of preventive health care. These programs will encourage individuals to maintain healthy life styles and take responsibility for positive health behavior.

Agencies such as the American Lung Association and the American Thoracic Society are ideally suited to provide leadership in this area. Public education is a primary tool used by the ALA/ATS to fight lung disease and promote lung health. We urge schools, families, health care providers, religious institutions, community organizations and others to join the voluntary health community in providing comprehensive health education.

FINANCING AND COST CONTAINMENT

ALA/ATS POSITION: Financing — *The financing of universal health care should avoid placing an inappropriate burden on any individual or particular sector within society and will require a degree of government support. Any premiums, deductibles, and co-payments for the basic level of services should be uniform. An individual's ability to pay shall not be a barrier to care.*

ALA/ATS POSITION: Cost Containment — *An employment-based health care system of universal coverage can be economically feasible only if there are cost containment features that address both aggregate budget expenditures and provider payments and are applied to all payers.*

We believe the health care system should be financed through multiple sources, including the government, with no one sector or individual bearing an unfair or disproportionate share of the costs. We support a progressively financed system and believe that any premiums, deductibles, or co-payments required must be based on an individual's ability to pay.

Finally, we believe cost containment is essential for maintaining a "healthy" health care system and that a variety of tools can be used to rein in the spiraling costs of health care. We suggest tools such as outcomes research, the development of clinical practice guidelines, reform of the medical liability system, electronic submission of claims, a single uniform insurance form, and such other tools as necessary to address aggregate budget expenditures and provider payments.

ALA/ATS Task Force on Health Care Policy

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**STATEMENT OF WILLIAM B. SPENCER
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Mr. Chairman, on behalf of the over 16,000 contractors, subcontractors, suppliers and related companies of the Associated Builders and Contractors (ABC), we greatly appreciate this opportunity to submit our comments concerning the "employer mandate" provisions of H.R. 3600, The Health Security Act. ABC members represent the majority of the construction industry which believes in the selection of bidders and performance of construction projects on the basis of merit, without regard to union or non-union status.

Although ABC supports the basic tenets of the President's proposal -- security, simplicity, savings, choice, quality and cost-sharing, we are troubled by some of the methods used to reach these goals, including the "employer mandate" provisions..

Construction is cyclical, with the number of employees working for a contractor rising and falling depending on the contractor's success in being the low bidder on a specific construction project. This scenario makes an employer mandate unworkable. While the need for insurance is constant, the cost of employers either continuing to cover employees during off-times or having to frequently cancel and reinstate workers based on the fluctuations in the number of construction projects they have would be financially impossible and an administrative nightmare.

Construction has been struggling with tough economic times. We are coming off of a five year decline in construction. During this recession our industry has lost a million jobs. If the employer mandate (which adds 7.9 percent to payroll costs) had been in place, one can only imagine how much earlier those jobs would have been lost to the economy.

Under the Health Security Act, employers will be required to pay 80 percent of their employees' insurance premiums. According to a Personnel Administrative Services' survey of one thousand merit shop contractors (ranging in volume from under \$500 thousand in revenues to more than \$50 million in revenues) the vast majority of companies are providing health insurance to their employees. In fact, more are doing so now than five years ago. As one might suspect, the figure for shared costs of the benefit has also risen.

The survey results show that for companies with less than \$500 thousand in revenues, 73 percent were offering health benefits to their employees in 1988 -- while this figure dropped slightly to 71% in 1993, in all other categories the number of firms offering coverage increased during the last five years. For businesses with revenues of \$500 thousand to \$1 million, 80 percent provided health benefits in 1988. That number increased to 86 percent in 1993, with shared costs actually decreasing from 35 percent in 1988 to 31 percent in 1993. Eighty six percent of companies with \$3-6 million in revenues provided health benefits to their employees in 1988 -- 90 percent are doing so in 1993.

These statistics indicate that contractors are voluntarily taking care of their workers. They are customizing benefits to local conditions and the unique characteristics of the construction workforce. We believe any health care reform must reflect the realities of the work place and that this type of flexibility is crucial for our industry.

The President's plan promises to help small businesses comply with the employer mandate by offering sliding scale subsidies for businesses with fewer than 75 full-time-equivalent employees and average wages of less than \$24,000 and offering premium caps from 3.5 to 7.5 percent of payroll, depending on the amount of average wages and the number of employees.. In reviewing the proposal, though, ABC is unconvinced that either of these accommodations will make it any easier for a construction employer to comply with the employer mandate. Without question, even though a business owner may want to provide coverage for his or her workers, in a business where companies succeed or fail based on a sealed bid, owners are forced to watch the bottom line. To do that and reduce operating expenses, the easiest place to

start is to cut payroll, especially lower wage, marginal jobs and all of the required payments which accompany those positions.

A recent Employment Policies Institute study estimates that the impact on construction from enforcement of the proposed mandate will be to increase labor costs by 5.1 percent. Economist Jacob Klerman of the Rand Corporation, appearing before the Senate Labor and Human Resources Committee in October, testified that "recent research on mandated benefits suggests that most, if not all of the increased labor costs -- net of any government subsidies -- will be passed on to workers in the form of lower wages." Although experts differ on the number of jobs lost from the imposition of a mandate, the Employment Policies study puts the potential job loss for construction at 241 thousand jobs.

Another potential loss that comes from implementing an employer mandate is that employers no longer would have the flexibility or opportunity to design health plans suited to the needs of their employees working in a specific industry. Employers will also lose control over their health plan costs. The government will tell them what to pay. As such, employers will become indifferent as they will have no involvement in the costs. This would be quite a contrast to today, where each employer has the ability to shop the market.

ABC believes an employer mandate destroys any motivation for businesses to take charge of their own health care costs. Once that occurs, the price of health benefits becomes relegated to a fixed business cost.

To assist construction employers in taking charge of their health care costs, ABC provides a variety of cost containment incentives, as well as a variety of health care plans. We began more than thirty years ago by first encouraging and then requiring second opinions. Today ABC provides a menu of benefits from the traditional fee for service programs with varying deductibles to Preferred Provider options or Point of Service programs, as well as Health Maintenance Organizations (HMO) in certain areas. This gives the small employer the ability to tailor a plan to include specific coverage or financial requirements.

In conclusion, ABC strongly opposes an employer mandate requiring all employers to contribute to the cost of health benefits for their workers. ABC believes, as does most other small business groups, that mandated coverage will force many new and marginally profitable businesses to close. It will greatly reduce the profits of more established companies and inhibit their ability to expand and create jobs. We advocate, that along with numerous other changes to the overall system, health care is best run on free-market principles. Therefore, health care changes must be accomplished through some means other than employer mandates.

**Statement for the Committee Record
by the
Computer Software Industry Association
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The Computer Software Industry Association (CSIA), with both company and association members, represents over 3000 software companies in California. We monitor proposed legislation and regulations affecting the computer software industry and educate our members, the California legislature, California regulators, Congress, and Federal regulators on the effects that proposed legislation and regulations will have on our industry.

We thank you for this opportunity to express our concerns about the employer mandates in H.R.3600, the Administration's Health Security Act.

Small businesses currently account for a large percentage of all jobs, and our economy is rapidly moving towards more and more service based jobs, rather than product based jobs.

CSIA's concern with the Health Security Act is that employer mandates coupled with the premium discounts for small businesses would give the IRS additional incentives to reclassify small service businesses as employees of their clients. This would negatively impact the financial health of those small business as the fear of an IRS audit would tend to prevent their prospective clients from doing business with small entities. Rather than regarding the rate discounts given to small businesses as incentive to inappropriately classify employees as independent contractors we should regard the rate discounts as an incentive to create more small businesses. Steps should be taken to ensure that payments to small businesses are properly reported through the 1099 system, but we also must take steps to eliminate the "penalties" for such reporting; fear of IRS reclassification audits.

CSIA believes that the solutions now in force to prevent this alleged abuse are a worse problem than the abuse itself. They are particularly onerous for technical services providers. Given that the burden of proof is always on the taxpayer when dealing with the IRS, and given the broad powers of the IRS, attempts to prevent "abuse" of the independent contractor relationship are instead resulting in the decimation of small businesses. This is a result not

only of IRS enforcement but of fear of inappropriate and overreaching IRS enforcement.

We believe that enforcement is driven by the unjustly large size of the penalties for misclassification, rather than any attempts to fairly collect taxes. This is even more apparent given the conclusion reached by a March 1991, Department of Treasury report which states that misclassification of employees as independent contractors increases tax revenues due to the tax-favored status of many employee fringe benefits.

There are many indications that IRS enforcement in these areas is not just and fair, but is instead unjust, unfair and extremely detrimental to the health of small businesses. For example, see the following:

- 1) Wall Street Journal article of 4/7/93, Page A14, in which IRS officials are quoted as saying that over half the nations self-employed should not be in business. A copy of this article is attached.
- 2) Another Wall Street Journal article detailing an example of unjust IRS application of Section 530. A copy of this article is attached.
- 3) The testimony of George Jacobs, in the July 23, 1992 hearings before the Subcommittee on Select Revenue Measures of the Committee on Ways and Means, House of Representatives (Serial 102-135, page 223-227), in which Mr. Jacobs describes the IRS' apparent war on businesses which use independent contractors, and in particular their attempts to drive him out of business.

While we applaud the health care act's attempt to provide relief for small businesses' health care costs, we fear that the additional provisions to allow the IRS to further decimate small service businesses will be far worse than the problem it attempts to solve.

Indeed, in 1978, Section 530 of the Revenue Act of 1978 was created to provide a safe harbor against IRS enforcement abuses. Section 1706 of the tax reform act of 1986 repeals Section 530 for "an individual who, pursuant to an arrangement between the taxpayer and another person, provides services for such other person as an engineer, designer, drafter, computer programmer, systems analyst, or other similarly skilled worker engaged in a similar line of work". This repeal, which has subsequently been shown to be completely unjustified¹, has devastated the computer consulting industry. Prior to 1978 there existed a very efficient network of computer consultants and brokers who were able to offer services to a variety of clients. This network has now broken

¹ "Taxation of Technical Services Personnel: Section 1706 of the Tax Reform Act of 1986" March 1991, Department of Treasury (PB91-172973)

down, forcing many consultants, who wish to remain self-employed, to turn down work formerly available on a contract basis which is now offered only on an employee basis. Further market inefficiencies exist in the inability of companies to obtain the skilled technical expertise needed since company policy now frequently prohibits use of independent contractors at all, due to the fear of unreasonable IRS audits. The most skilled technical experts typically refuse to accept work requiring them to become short-term employees. This is due to their existing investment in equipment and training, as well as their ability to provide consistency in their own self-provided retirement and health care benefits.

In spite of the continuing problem with over-enforcement, the health care act now proposes to eliminate or weaken even the inadequate Section 530 protection for all businesses, thus declaring open season on small service businesses. This will devastate services industries just like it has the computer consulting industry.

Is it not better to allow an unemployed worker to become self-employed and pay PART of his or her health care costs than to discourage self-employment, forcing the worker to remain unemployed and pay NONE of those costs?

The fact that the classification problems are both widespread and long-standing is evident by the quantity of reports which have been written on the problem. Indeed, there is at least one report on all the other reports, "Independent Contractors: Compliance and Classification Issues" by the Tax Policy Institute. We recommend the solution proposed in this report, namely, that a "safe haven", based on a clearly defined subset of the current common law rules, be created.

Rather than making the current problems worse, we recommend resolving them in two parts:

- 1) Redirect IRS enforcement activities away from reclassification and towards information reporting by eliminating retroactive reclassification penalties under certain safe haven conditions (detailed in part 2) and by increasing penalties for not filing information returns (1099s).
- 2) Create a safe haven from retroactive reclassification, as recommended by the American Tax Policy Institute in their report "Independent Contractors: Compliance and Classification Issues". The report recommends a safe haven which combines several of the models it reviews and which would classify 93% of workers in a manner consistent with a database of facts and final classification results

obtained from 321 IRS determination letters. The recommendation is as follows:

Workers would be excluded from the common law definition of "employee" if they met at least one of the following four tests:

- 1) Can suffer a loss or make a profit**
- 2) Have a principal place of business other than the service-recipients**
- 3) Generally make services available to the public as self-employed individuals.**
- 4) Work for three or more service-recipients on a non-exclusive basis during the current or previous year.**

In addition, several compliance-oriented requirements would also have to be met--such as the maintenance of books and records; the existence of a written agreement; and attestation that the necessary self-employment and income taxes will be paid. Those not meeting the new safe haven rules or the existing Section 530 safe harbor would rely on the common law rules.

Given that it is impossible to require businesses to hire more employees than they need, an important safety valve for the unemployed is their ability to become self-employed and to thereby offer their services on that basis. As we move from a product-based to a service-based economy we must realize that economies of scale are realized by allowing companies to specialize in services needed by other companies on a non-permanent basis. The vast majority of jobs are created by small businesses and many of those small businesses are service based. We must allow them to start, grow and prosper without undue interference. While abuse is of concern, we must NOT be so concerned with eliminating abuse that we also eliminate small businesses. Allowing the IRS to interfere in this process by making companies fear doing business with small service providers is not good for the economy or for people in general.

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THE WALL STREET JOURNAL WEDNESDAY, APRIL 7, 1993

The IRS vs. the Self-Employed

By JAMES BOVARD

The Internal Revenue Service is carrying out a sweeping campaign to slash the number of Americans permitted to be self-employed—and to punish the companies that contract with them. The IRS's attack has devastated thousands of small businesses and is undermining high-tech industries, the health-care industry, and even freedom of religion. IRS officials indicate that more than half the nation's self-employed should no longer be allowed to work for themselves.

This controversy originates in arcane federal regulations on the proper classification of workers. If a person is an employee, the employer must withhold all of that person's payroll taxes and remit them to the IRS, pay half of the employee's Social Security taxes and all of the unemployment insurance tax. But if an individual is an independent contractor, a business need only file a Form 1099 with the IRS reporting how much it paid that person, and the contractor pays his taxes directly to the IRS.

The IRS has long sought to forcibly reduce the number of self-employed Americans and maximize the number subject to tax withholding. The IRS enforcement campaign is targeting businesses with less than \$3 million in assets—in most cases, businesses without in-house counsel that cannot afford a lengthy court fight. The House Government Operations Committee concluded in a report in November that "IRS' enforcement activities [on independent contractors] present small business taxpayers with a veritable nightmare of problems and policies that defy common sense."

Master and Servant

The IRS bases its classification decisions primarily on a list of 20 questions on the relationship between the employer and the contractor/employee. These questions are derived from common law precedents dating to the Middle Ages. An assistant U.S. Treasury secretary admitted in 1981 that the common law employment test was "developed centuries before the income tax to determine the rules of the doctrine that the master is liable for the torts of his servant." A 1991 Treasury Department report conceded that "the common law tests... lack precision and predictability" and in many cases do not "yield clear, consistent, or satisfactory answers."

Once an IRS agent announces that a company has misclassified its employees (as happens in nine of 10 audits), the com-

pany often faces a staggering tax bill—largely because the IRS intentionally forces businesses to double-pay taxes already paid by independent contractors. The House Government Operations Committee noted: "The assessments are based on the use of preset mandatory formulas which even the IRS admits result in double tax collections. These back tax assessments have been responsible for putting a number of those businesses out of business." IRS agents have assessed more than \$500 million in penalties and back taxes since 1988 (averaging \$68,000 per company) and forced businesses to reclassify over 400,000 independent contractors as employees. (The IRS is now "con-

The IRS enforcement campaign is targeting businesses with less than \$3 million in assets—in most cases, businesses that cannot afford a lengthy court fight.

verting" almost 2,000 independent contractors into employees each week.)

These businesses, in most cases, have not broken any clear law or manifested any intent to dodge taxes. Harvey Shulman, counsel for the National Association of Computer Consultant Businesses, observed: "I have had grown men and women—40 or 50 years old—cry on the phone to me, telling me that their marriage is threatened, they are seeking counseling, all because the business that they built up in the last 15 years of their lives—the house and other things they've earned from the fruits of their labor—is all threatened by this IRS employment classification audit. They ask me, 'What did I do wrong? Why am I being persecuted?'"

Many IRS officials threaten harsh penalties to coerce businesses to sign agreements promising not to use independent contractors in return for a reduction or waiver of the taxes and penalties. Such perpetual cease-and-desist orders may be appropriate when the government is dealing with wife-beaters or child molesters, but they are bizarre when it is seeking a pretext to permanently control the day-to-day operation of small businesses.

One industry that is especially hurt by the IRS crackdown is health care. Marc Catalano, president of the Private Care Association, an association of health-care agencies, accused the IRS of following a "search and destroy posture with respect to businesses that use independent contractors." Comprehensive Care Corp. was hit in 1991 with an IRS demand for \$13.4 million in back taxes and penalties for treating psychologists and physicians as independent contractors.

John Bailey, a psychologist at the Family Therapy Center of Madison, Wis., complained to a congressional committee last August that his clinic "has come under attack.... The IRS methods have been too subjective, applied with ferocity and arbitrariness, and have caused untold grief for us and other well-meaning small businesses." Mr. Bailey reported that the IRS "attack has threatened the very survival" of several Wisconsin clinics.

The IRS tried to penalize several Pennsylvania corporations for paying dentists as independent contractors instead of employees. But the Pennsylvania Dental Board had warned the corporations that it would be illegal under state law for the cor-

porations to hire dentists as employees, since the corporations themselves were not licensed to practice dentistry. A federal judge threw out the IRS's case in 1991.

The IRS is launching a high-profile assault on the use of independent contractors in Hollywood. The IRS began a similar crackdown on the Minnesota film industry last year. One Minnesota film producer complained to a local magazine that IRS agents "want me to classify a lighting tech who works for two hours and who I never see again as a part-time [employee]. That's absurd."

In some regions, IRS officials have ordained that all United Methodist ministers must be reclassified as employees. The Rev. Robert McKibben of Alabama informed the House Ways and Means Committee that he was told by an IRS examiner that "all ministers" are "statutory employees." Mr. McKibben informed the IRS agent of a U.S. Tax Court decision upholding the self-employment status of United Methodist ministers, but the IRS official said he was not bound by the ruling.

Mr. McKibben observed that the systematic misclassification of ministers "results in... the IRS dictating to the church the type of relationship they must have." Craig Hoskins, counsel for the church, estimated that more than 1,000 Methodist clergymen have faced IRS audits over their employment status. (The IRS has not yet attempted to impose penalties on God for not withholding taxes from the ministers' pay.)

High-tech industries have probably been hit hardest by the IRS's crackdown. In 1978, Congress enacted a provision to



prevent the IRS from penalizing companies that had a "reasonable basis" for classifying people as independent contractors. But in the 1986 tax act, Sen. Daniel Patrick Moynihan (D., N.Y.) slipped in an amendment—Section 1706—that revoked the "reasonable basis" protection for engineers, computer programmers and other technical service professionals.

A 1987 Data Processing Managers Association survey found that 74% of firms decreased their contracts made directly with independent technical service consultants as a result of Section 1706. Rep. Major Owens (D., N.Y.) said last year that "many African-American computer programmers and analysts have had the door to self-employment slammed in their faces because of Section 1706."

IRS agents are often heavy-handed in how they carry out employment tax audits. IRS officials have encouraged private companies to secretly betray their competitors. At a 1990 meeting in California, an IRS agent distributed "snitch sheets" to business people and asked them to make allegations of illegal independent contractor use by other companies. The IRS agent told attendees to mail the completed snitch sheets to him in unmarked plain envelopes and promised to follow up all leads.

Tax Dodging

The IRS estimates that 3.4 million Americans now working as independent contractors should be reclassified as employees. The Small Business Administration says that there are roughly five million independent contractors. Thus, more than half of all the independent contractors in the U.S. could be forced to find a boss.

The IRS justifies its crackdown because some of the self-employed dodge taxes. But the Treasury Department concluded in a 1991 report on technical service workers: "Misclassification of employees as independent contractors increases tax revenues... and tends to offset the revenue loss from undercompliance by such individuals, because direct compensation to independent contractors is substituted for tax-favored employee fringe benefits."

The IRS apparently believes that payroll tax withholding is more important than Americans' freedom of contract. Being self-employed and starting one's own business have long been part of the American Dream. But the IRS has apparently decided that it can no longer afford to permit others to pursue their dreams.

Mr. Bovard, an independent contractor, writes frequently on public policy.

THE IRS MUST PAY for misclassifying workers as independent contractors.

This is a rare victory for an employer, notes Forrest Milder, a Boston lawyer. It comes as the IRS is cracking down on firms that don't withhold income taxes or pay Social Security taxes for workers who really are employees. Apollo Drywall kept seven or eight drywall installers on its payroll as employees and hired up to 23 contractors as needed. But the IRS claimed that under a law known as Section 530, the contractors had to be treated as employees because they did the same work as the employees.

Although it knew the contractors worked without supervision and also for other companies, the IRS demanded back taxes and penalties. Apollo paid and sued for a refund. After losing in pretrial maneuvers, the IRS agreed to a full refund, \$26,112. Then Apollo sought legal costs. Now U.S. Magistrate Judge Sooville in Michigan says Apollo is entitled to fees and costs because the IRS completely misread Section 530 and took an unjustified position in the dispute.

A reasonably objective person who considered the known facts would see that the contractors weren't employees, the judge commented.



January 25, 1994

The Honorable Dan Rostenkowski:
US House of Representatives
Washington DC 20515

Dear Congressman Rostenkowski:

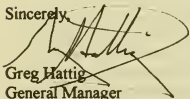
The upcoming healthcare hearing scheduled for February 3, 1994, in the Ways and Means Committee is of grave concern to The Promus Companies hotel systems, the entire Hospitality Industry and to me personally.

The lodging industry provides jobs to those who need them most. We are proud to offer employment opportunity, but we cannot provide the level of benefits mandated in the Clinton plan. We can provide work for many people with little economic opportunity, and our ability to do so is threatened by more liberal employer mandates. What ever happened to our Free Enterprise system of business? If the employer is unable to provide such costly benefits, let the employee find employment where such benefits are offered. Would you rather have the costs of lodging skyrocket across the board, making the cost of doing business for all businesses go up that much more?

We take pride in the fact that a large percentage of the jobs we create afford people with little or no previous job skills the opportunity to become employed. We all spend alot of time, effort and dollars to train these employees. The knowledge and skills that we teach these employees will benefit the in future job endeavors both in the hospitality industry and elsewhere.. By providing access into the job market, these jobs have created opportunities for individuals to learn basic job skills. Despite the tendency of many to disparage these jobs in favor of the "high tech" jobs, the people who work in this industry need this basic type of employment to get started in the job market. Our employees frequently lack the education or experience to compete in many areas of the job market and would be denied the ability to work but for our industry and similar industries in the service sector of the economy.

There are many other alternatives to the Clinton plan, please do anything you can do to oppose another employer-mandated, government-operated solution. It seems ridiculous to me to have the waste ridden government bureaucracy running another 14% of our GNP!

Sincerely,


Greg Hattig
General Manager

HAMPTON INN-DENVER SOUTHWEST

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Operated by Signature Hospitality Management

STATEMENT
of
THE NATIONAL ASSOCIATION OF HOME BUILDERS
before the
COMMITTEE ON WAYS AND MEANS
of the
UNITED STATES HOUSE OF REPRESENTATIVES
on
THE EMPLOYER MANDATE AND RELATED PROVISIONS WITHIN
THE ADMINISTRATION'S HEALTH SECURITY ACT
February 3, 1994

Mr. Chairman and Members of the Committee:

The National Association of Home Builders (NAHB), on behalf of its 169,000 member firms across the country, is pleased to take this opportunity to comment for the record on the employer mandate and related provisions contained within the Administration's comprehensive health care reform proposal, also known as the Health Security Act (H.R. 3600). We congratulate you for holding this important hearing and stand ready to work with you to help achieve a meaningful and proper consensus on health care reform as this significant debate continues to unfold.

To be sure, NAHB's membership feels strongly that the U.S. health care delivery system, despite its flaws, continues to be identified as the highest quality provider of health care in the world. That is not to say that home builders do not also recognize that even the finest system can be improved to better meet the needs of the American people. Nonetheless, NAHB continues to oppose the federal imposition of a broad employer mandate, such as H.R. 3600's requirement that all employers pay 80% of the average weighted premium cost of a defined comprehensive health benefits package, as the means to provide universal health insurance coverage to our nation.

And although NAHB appreciates H.R. 3600's well-intentioned provision for small business premium discounts/subsidies based on a firm's average payroll size and its workforce size (Section 6123), we remain concerned that these discounts (which presumably will cap a small employer's premium cost burden within a sliding scale of 3.5 to 7.9% of annual payroll) will always be subject to upward change by the Congress should the enormous amount of revenue necessary to finance such a comprehensive program fall short of projections.

In short, NAHB remains convinced that a mandated health benefit requirement will severely restrict the flexibility of employers -- especially within an industry as cyclical as residential construction -- to best tailor health insurance coverage to meet their workers' needs. While the need for insurance is constant, the cost of employers either continuing to cover employees during downtime or having to frequently cancel and reinstate workers based on the fluctuations in construction activity would be, at best, an administrative nightmare. And quite frankly, many home builders -- like most small employers -- simply do not have the wherewithal to provide such a specific benefit without first eliminating jobs or passing along increased product costs to the housing consumer.

INDUSTRY PROFILE

Many mistakenly envision the typical home builder as a "high-volume" constructor, someone with the perceived ability to spread production and regulatory costs across many projects. In contrast, the majority of NAHB member firms are truly small businesses, primarily engaged in home-remodeling and the construction of single family homes. To a lesser extent, NAHB members are engaged in light commercial projects and the erection of multi-family residential structures. Indeed, over half of our members build fewer than 10 homes per year and close to 75 percent of our members build 25 or fewer homes.

However, because the construction of a home entails the transportation to a job site of a wide variety of different materials which are assembled and/or fabricated by a host of different trades, and because job sites necessarily change as the homes are built, the relationship between the builder and the person who performs the different housing trades varies widely. Beyond their immediate family, many builders may not hire a single "captive" employee. Indeed, the construction of single family homes is typically the coordination of the work of as many as 18 different subcontractors.

Bearing these facts in mind, NAHB's Economics Division conducted a comprehensive survey of builder members in late 1993 in an effort to better assess the true nature of health insurance coverage across the housing industry. This Health Care Survey revealed the fact that a clear majority of builders sampled already voluntarily provide some form of health care benefits as part of their employees' overall wage/fringe benefit compensation package. Roughly two-thirds (63 percent) of the building firms surveyed provide coverage for their employees only, or for their employees and their dependents.

Not surprisingly, small building firms are far less likely to provide coverage than larger firms. Only about 47 percent of the firms with 1 to 4 full-time employees on payroll offer health insurance to all or some of their employees. That share rises to 67 percent for firms with 5 to 9 full-time employees, to 79 percent for firms with 10 to 24 full-time employees, to 91 percent for firms with 25 to 49 employees, and to 99 percent for firms with 50 or more employees.

This share of firms providing some form of coverage to employees is fairly typical of industries (such as housing) with a heavy concentration of small firms. However, according to certain independent estimates, the extent of health insurance coverage among small home building firms is better than the national small firm average. Indeed, the Health Insurance Association of America has found that only about one-third of firms with fewer than ten employees offer health coverage to any of their employees.¹

Of the home building firms that currently provide employee health insurance, 40 percent offer coverage to their employees only, and 60 percent offer it to employees and their dependents. The percentage of firms offering health insurance to employees and dependents does not vary much by firm size for those firms that employ fewer than 50 employees (from 57 to 61 percent), but is significantly higher for firms with 50 or more employees (71 percent).

Going further, the survey also revealed that most of the home building firms that provide health coverage for at least some of their employees pay 100 percent of the health insurance premiums for individual plans. Three-quarters pay the full premium, 23 percent pay from 50 percent to 99 percent of it, and only two percent pay less than 50 percent. A majority of the firms that offer family coverage (63 percent) pay the full insurance premium. Thirty-two percent pay from 50 to 99 percent of the premium, and only five percent pay less than 50 percent of the premium.

¹ Cited in Michelle A. Clark, "Health Insurance in America: Searching for a Cure," *The Regional Economist*, January 1993.

On average, 83 percent of those eligible for an employer-provided health plan participated in one. The percentage of eligible employees participating in health plans varies very little with firm size. The smallest and largest firms surveyed have the highest average participation rates (86 to 88 percent) and medium-sized firms the lowest (79 to 80 percent).

EMPLOYER MANDATE

For now, the Administration estimates that the average cost of a family policy under the new system contemplated by H.R. 3600 would be \$4200 a year. The employee would have to pay up to 20 percent of the average weighted premium cost, with the remainder coming from his or her employer. In short, the employer has an 80 percent mandated payment responsibility. Small businesses with low average wages would be able to "buy in" at fixed premium rates.

The proposal defines a full-time employee as one working 30 hours or more a week. If an employee works less than 30 hours, the employer must pay a pro rata share of the costs based on the ratio of hours worked to 30 hours. It is not yet clear from the proposal how seasonal workers will be treated, although it appears the employer will be liable for some contribution based on the number of hours worked. Self-employed individuals may pay the employer share and the individual share of the appropriate premium, e.g. individual, couple, single-parent family, two-parent family. At present, premium contributions would be made to H.R. 3600's proposed system of regional health alliances at least quarterly. The employer share paid by the self-employed person would also be capped as a percentage of income, using the percentage caps applied to small businesses in the alliance.

These proposed changes must be compared with the snapshot provided by our 1993 Health Care survey results and, more importantly, viewed within the context of their likely effect on a small firm-dominated industry such as residential construction. Since the volume of work in the housing industry is very unpredictable and necessarily seasonal, there is a strong need for builders to match their labor costs to business needs. They must therefore tailor benefits to local conditions and the unique characteristics of the construction workforce. As a result, we believe that any type of health care reform must reflect the realities of that workplace and the type of flexibility so crucial to our industry.

Our survey statistics indicate that a majority of builders are voluntarily taking care of their workers under the current system. However, the implementation of a mandate such as the one found within H.R. 3600 would deny employers the opportunity to design health plans best suited to the needs of their employees within a specific industry. In essence, the mandate would become nothing more than a fixed business expense. Employers would no longer exercise control over their health plan costs, but instead be reduced to the range of options provided through government review and oversight.

As part of our survey exercise, NAHB also polled builders for more specific opinions on the Administration's proposed health care mandate. While roughly half of the respondents supported proposals which would "provide incentives for people to use lower cost options [such as managed care networks]," a clear majority of firms opposed the notion that the government should "require all employers to provide medical coverage to their employees and their families."

How would a typical small building firm likely react to such a payroll tax/mandate? One obvious option would be to raise product price -- a tactic apt to damage a builder's competitive position even under today's more favorable housing market conditions -- to the detriment of the consumer seeking to find an affordable home. Another option would be to reduce workers' wages to cover increased payroll costs. A final option would be to let one or more employees go and then limit hiring to the greatest extent possible. We fear that the third option is the one most likely to occur.

NAHB is not alone in this assessment. Numerous respected CEO's, academicians, economists, trade groups -- and Members of Congress -- have all agreed that the mandate will lead to small business job loss. Even the White House Council of Economic Advisors has acknowledged that up to 600,000 jobs could be lost under the President's plan. The small business subsidy scheme is in and of itself an admission of the burden this mandate will place on small firms.

SLIDING DISCOUNT/SUBSIDY SCALE FOR SMALL BUSINESS PREMIUMS

Employers with fewer than 75 workers and average annual wages of less than \$24,000 would be eligible to contribute a lower health premium amount based on a sliding scale ranging from 3.5 percent to 7.9 percent. To prevent the subsidies from becoming an "open-ended" entitlement, the bill caps the amount of subsidies available. If the limits are exceeded, the President would be required to make recommendations to Congress suggesting how to make up the shortfall. If more money is not authorized, the subsidies may be reduced, benefits could be cut back, or premiums increased.

Although many builders who are already providing employee health coverage could stand to benefit from available subsidies, that assumption holds true only if the Congress and Administration correctly allocate the proper amount of funds for this new small business entitlement. One need only look back to Medicare to find an example of inaccurate entitlement projections. In 1965, the Medicare program was estimated to cost only \$9 billion by Fiscal Year (FY) 1990. Instead, FY '90 program costs were actually \$116 billion! Should the government's revenue projections for H.R. 3600 prove to be similarly inaccurate, we believe that the small business subsidy would most likely be phased out and the payroll tax/mandate cap raised.

Furthermore, H.R. 3600 provides authority for the fifty states, the proposed National Health Board and/or the Congress to adjust the Clinton plan's "Fortune 500"-style standard benefits package. Should that package's benefits be adjusted upward, the small business subsidy will cover less and the employer mandate would inevitably cost more. In short, NAHB remains unconvinced that the bill's subsidy scheme will sufficiently ease the burden of compliance with the proposed employer mandate.

CONCLUSION

NAHB recognizes that many members of the Committee believe that the employer mandate is an indispensable element of the President's plan and that true health care reform cannot take place without it. We respectfully disagree with that assumption. There are clearly a host of other steps which this Committee and this Congress must explore before resorting to such a potentially damaging coverage tool. So-called incremental reforms such as 100% deductibility of health insurance costs for the self-employed, the creation of more voluntary small business purchasing groups, small market insurance reforms, medical malpractice reform, and administrative simplification are but a few of the alternatives that represent the emerging reform consensus.

Therefore, NAHB urges the Administration and Congress to create an environment which will encourage, support and provide incentives to our free enterprise system through a market-based approach to health care reform that will:

- 1) Provide universal access to health insurance for legal residents, rather than guaranteed/mandated coverage;
- 2) Improve access to health care at the individual level by providing a refundable tax credit for health expenses for low-and moderate-income Americans, permanently increase the tax deduction for health insurance costs of the self-employed from 25 percent to 100 percent and promote tax-deferred individual medical savings Individual Retirement Accounts ("Medisave" accounts);

- 3) Enact meaningful medical malpractice reforms;
- 4) Promote cost containment; and,
- 5) Preserve existing association-sponsored health programs as viable mechanisms for pooling risks and increasing the market leverage of small employers.

NAHB also reaffirms its strong opposition to:

- 1) A broad employer mandate as the vehicle to provide health insurance/universal coverage to all employees;
- 2) Any attempt to reclassify independent contractors as employees for the purpose of mandating health coverage;
- 3) Any attempt to change the treatment of Subchapter S and partnership income to increase taxes to pay for health care; and,
- 4) Federal control of the state-based workers' compensation system.

NAHB again thanks the Committee for this opportunity to present our views for the record on the employer mandate and related provisions of H.R. 3600.



National
Association
of Hosiery
Manufacturers

200 NORTH SHARON AMITY RD • CHARLOTTE, NORTH CAROLINA 28211-3004 • TELEPHONE: (704) 385-0913 • FAX: (704) 382-2056

February 15, 1994

Ms. Janice Mays
Chief Counsel and Staff Director
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

RE: H.R. 3600 - Health Security Act
Employer Mandate Provision

Dear Ms. Mays:

The National Association of Hosiery Manufacturers (NAHM) is the trade association representing the interests of those companies in the United States that produce all types of men's, women's, and children's hosiery. Our members manufacture and market approximately 85 percent of all the hosiery sold in the United States.

The NAHM understands the employer mandate provision in the Administration's Health Security Act (H.R. 3600) would require employers to insure all workers and pay at least 80 percent of premium costs, with employer costs capped at 7.9 percent of total payroll. Conservative estimates now place new employer spending for the Administration's plan at \$70 billion per year. Employers would be assessed additional premiums to cover the costs of Federally financed programs including academic health centers and graduate medical education alliance administrative costs, and collection shortfalls. The business and industry community has been attempting to cope with unnecessary and inefficient employer mandates for years, and now the Administration's health reform proposal threatens to create another level of federal bureaucracy and impose new costs on struggling small businesses. The latest estimates indicate the Administration's proposal would also increase each employee's taxes by \$5700 per year.

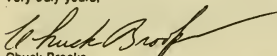
Unfortunately, H.R. 3600 would create a burden of high employer premium contributions, rich benefits, and counterproductive regulation. The NAHM believes that market-based solutions are the best approach to health care reform because they create incentives for employers to finance and administer benefits, providers to deliver quality care, and consumers to use benefits wisely. A massive new entitlement would further drain U.S. vitality and competitiveness and add to our staggering deficit.

The Association supports a private sector-based health care program with built-in cost containment strategies and structured to assure competitively-priced services and products. The Association further supports the concept of universal health care access on at least a basic level. Accordingly, users would be guaranteed a specified level of coverage, required to pay into the system in some manner, and educated in the efficient utilization of health care programs.

Cost containment strategies would promote preventative care and eliminate waste, oversupply of technology, and excessive over-treatment of patients. Medical malpractice reform would be an inherent component of an improved health care system. The present method of cost-shifting should be structured in a manner which provides equitable burden-sharing for users.

The NAHM appreciates the opportunity to submit comments on H.R. 3600. If I may be of any further assistance, please feel free to contact me.

Very truly yours,


Chuck Brooks
Vice President/Secretary

CB/jb

**STATEMENT OF LAURA MCGUIRE MACKAIL
EXECUTIVE DIRECTOR
NATIONAL TECHNICAL SERVICES ASSOCIATION**

Overview

How best to accommodate the health and welfare needs of contract technical employees who work on projects which are limited and temporary in nature is a subject of extreme importance to the members of the National Technical Services Association (NTSA). As employers of generally high skill, high wage technical professionals, NTSA firms are uniquely qualified to comment on the need to expand access of portable health insurance products to this vital, productive component of the U.S. labor force.

NTSA firms support the concept of universal access to health insurance. NTSA submits testimony today favoring health care reforms which facilitate the establishment of voluntary health insurance purchasing cooperatives, the elimination of the pre-existing condition restriction and the implementation of tax incentives to encourage the purchase of health insurance. These changes will provide both access to high quality, guaranteed-issue medical insurance products at affordable prices and the portability required by the growing ranks of Americans (including contract technical employees) whose careers -- today more than every before--require frequent job changes.

We believe, however, that a complex, new federal/state government bureaucracy with rigid employer mandates (administrative and financial) such as those proposed in HR 3600, is not necessary to fix what needs fixing in our current health care system. We urge Congress to focus on reforms designed to improve health care access while leaving particular decisions such as purchasing and financing such insurance coverages to individuals and/or employers to decide.

Technical Services Companies

Since World War II, technical services companies have recruited and employed skilled personnel such as designers, drafters, engineers, computer programmers and systems analysts and assigned them to work in their customers' facilities to satisfy their customers' temporary needs for such skilled services. These needs generally arise in connection with new product development, special projects or peak period work loads when, for a limited period of time, a customer needs additional skilled manpower to supplement its regular workforce. Through the services of technical services companies, the customer can quickly assemble teams of personnel with just the right technical skill to satisfy these particular, but limited duration, staffing needs. Customers are able to "staff-up" and "staff-down" quickly, effectively and efficiently to meet their limited duration needs for additional technical talent. This ability to gear overall workforce size to the particular job at hand assists companies in their struggle to control costs and be competitive and to provide higher quality and greater value for their customers in today's increasingly demanding global economy.

Contract Technical Employees

Contract technical employees choose to work on this temporary assignment basis and, in many cases, to make a life-long career out of it, for two primary reasons: challenge and variety. Working in the technical services industry often gives technical services employees the opportunity to challenge and expand their skills by working on "cutting edge" projects which involve the development of new products or the application of new technology. And contract technical employees enjoy the variety of working in different geographic locations and job environments and with different co-workers. Job assignments can take the contract technical employee to the different corporate cultures of different customers, to different parts of the country and even different parts of the world.

The very nature of these job assignments, though, is that they are temporary. According to research conducted for NTSA by an independent research firm, the average length of a project assignment (based on a population of approximately 215,000 employees at the time of the research) is about 7 months.

Our employees recognize that they will make frequent job changes. Our industry is customer-driven and highly susceptible to all of the economic and global forces which drive demand for this business service. And while this mobility often makes for interesting and varied careers, it also makes the provision of health and welfare benefits impracticable under the system proposed in HR 3600.

Health Insurance For Contract Technical Employees

The health insurance needs of our technical employees are fairly simple: for those who *want* health insurance, it should be available, affordable and *portable*. But the health insurance alternatives currently available to these employees do not meet these needs.

Coverage under employer sponsored programs (virtually all NTSA companies make coverage available) will end when the employee's assignment and employment ends (or when the follow-

on COBRA period ends). The employee can't take it with him after his assignment, so this coverage is not viewed as being very valuable. Consequently, few employees choose it.

Individually-owned health insurance provides the portability, but by choosing this route our employees often pay higher than average insurance premiums in after tax dollars.

For the past 5 years, NTSA has worked with health insurance administrators and a number of A Best Rated insurance companies in an effort to create and make available a range of health insurance products for contract employees. Our goal has been to offer a traditional, fully-insured major medical indemnity program which provides for individually owned coverage at affordable group rates. Though we have made some progress with the portable health plan concept, we have also experienced difficulties. First,, coverage is not always available in every state due to various state insurance filing requirements. Second, we have found great resistance on the part of traditional insurers to underwrite a guaranteed-issue major medical product.

Despite the unique health insurance access needs of our industry, we do not believe it is necessary to dismantle the current health insurance system and replace it with huge government bureaucracy, employer mandates and the like in order to deal with these shortcomings. What would materially address these shortcomings, however, is a system of guaranteed access to portable health insurance at pricing, and with tax consequences, which are the same whether purchased through an employer or not.

To do this, NTSA believes that three straightforward reforms should be adopted.

1. The pre-existing condition restriction on obtaining insurance should be eliminated. This would greatly expand access to quality coverage.
2. The formation of cooperatives for the purpose of purchasing health insurance should be permitted and liberalized. Many of the purchasing cooperative reforms today provide favorable treatment for small employers (usually defined by state law to apply to firms with 50 or less employees), yet many low margin, high turnover industries exceed these employee thresholds and cannot tap these effective resources.
3. Health insurance premium payments should be made 100% tax deductible by whomever pays them, but out-of-pocket payments for health care services not be tax deductible. This would both equalize the tax consequences of purchasing health insurance and encourage the purchase of such insurance.

Ease the Burden of Compliance

For the many companies in this country that have operations in more than one state, the burden of trying to deal with the myriad of state insurance regulation is daunting. It is simply hard to imagine that the value gained by enabling states to create minor customizations to plan design requirements would justify the tremendous burden of compliance.

Through our analysis of HR 3600, for example, a typical firm operating in 3 states might interact with 10 different regional health alliances each offering 50 or more plans. Combine these options with the 4 different family types, and your result is 6000 different health insurance plan options to be managed by one employer. If each state is allowed to further tinker with basic benefit plan requirements, the burden of compliance might very well double or triple.

These burdens simply add cost which hamper the ability of American companies to compete while providing little, if any, real benefit. And this burden falls the hardest on low margin, high turnover industries--such as the contract technical services industry--which are less able financially to manage the administrative requirements associated with employer provided health care programs.

We strongly urge that the final rules in this area provide for preemption of state regulations by the federal rules.

Summary Remarks

NTSA members believe that their technical employees will be best served by instituting health insurance reforms which give individuals as well as large and small businesses wide latitude in the decision to purchase and/or finance health insurance products. Reforming the insurance market as outlined above will help our employees the most.

NTSA is a trade association comprised of over 170 member companies in the technical temporary and contract technical services industries. Member firms employ more than 200,000 highly skilled, highly paid employees annually. Virtually all member firms make health insurance coverage available to their workforce. We thank you for the opportunity to comment on this very important issue and would be happy to furnish additional information you might require.

**STATEMENT OF PHILIP P. FRIEDLANDER, JR.
EXECUTIVE VICE PRESIDENT
NATIONAL TIRE DEALERS AND RETREADERS ASSOCIATION, INC.**

Mr. Chairman, the National Tire Dealers and Retreaders Association, Inc. appreciates the opportunity you have afforded us to submit to the Ways and Means Committee the association's views on health care reform, and specifically the President's proposal to require employers to provide health insurance coverage to their employees. NTDRA is a national non-profit trade association representing nearly 4,500 independent tire dealers and retreaders located in all 50 states who are engaged in the wholesale and retail distribution of automobile and truck tires, the retreading of tires and the sale of related products and automotive aftermarket services. NTDRA's members own and operate an estimated 15,000 retail outlets and account for roughly \$12 billion in sales annually.

NTDRA believes the current debate on reforming the nation's health care system is healthy. We commend the administration for helping to focus the nation's attention on many of the problems that currently exist in our health care delivery and health insurance systems. We commend the Ways & Means Committee for holding hearings and for reviewing a variety of health care reform alternatives.

In your consideration of the various proposals before you, we want the committee to understand that NTDRA is unalterably opposed to any health care reform proposal that includes a government mandate requiring employers to pay for all or part of health insurance costs for employees. We believe an employer mandate would cause severe harm to tens of thousands of small businesses, many of their employees, and to the nation's economy as a whole.

The debate in recent years on health care reform has often been as confusing as the health insurance forms most of us are required to fill out at one time or another. For some advocates of reform, the stated goal is universal access to "affordable" health care. For others, the goal is universal access to "affordable" health insurance. Because of these conflicting goals, we see a broad range of often dissimilar health care reform proposals. They range from single payer systems to managed competition, from employer mandates to individual mandates, from universal coverage to health care savings accounts. And all too often the emphasis appears to be on access to "affordable" health care rather than "quality" health care.

The United States may well have the best health care system in the world. However, millions of Americans lack health insurance to cover costly medical emergencies. The reasons are numerous. Some cannot afford it. Some believe they don't need it, and choose to spend their money on other goods or services. Some have previously existing health conditions and cannot get insurance at any price. Some lose their insurance when they change jobs or lose their job. Whatever the reason, tens of millions of Americans lack health insurance.

America's small business owners are familiar with all of these scenarios. Small businesses generally face higher costs for health insurance than do larger businesses due, in part, to higher administrative costs. Small businesses are more likely to experience increased insurance costs when they have high claims experience or employees with previously existing conditions. Small businesses are more likely to see their insurance costs impacted by state benefits mandates than larger firms because, unlike large businesses, most small businesses cannot afford to self insure. Smaller businesses generally have higher rates of employee turnover and higher rates of business failure. Small businesses are more likely than their larger competitors to have their coverage canceled by their insurers.

NTDRA believes that most small business owners want to provide their employees with access to health insurance. Based on rough data that we have collected, it appears that somewhere between 70% and 80% of NTDRA's members offer their employees access to health insurance coverage. Access to health insurance is an important fringe benefit when an employer is seeking to attract quality employees

in a competitive job market. Most NTDRA members pay a share of the employees' coverage and many share in the costs of dependent coverage.

NTDRA operates an insurance trust in an effort to provide an important economy of scale service to its members. We, therefore, have frequently reviewed studies over the years as to why a majority of small businesses do not provide their employees with health care insurance. Most studies indicate that cost is the major inhibiting factor. Furthermore, the smaller the business, the less likely it is to provide health insurance to its employees. For the tens of thousands of small business owners who would like to offer their employees health insurance coverage, but who have been unable to do so because of cost, a government mandate will not make a difference. No government mandate will miraculously make these businesses more profitable and able to afford the cost of employee health coverage?

Many NTDRA members, like thousands of other small businesses in our country, operate every day on a thin edge between success and failure. Keeping costs down is one of the primary ways by which small businesses manage to stay in business. For labor intensive sectors of the economy like retailing, managing labor costs becomes paramount. Unfortunately, small business owners have limited means of controlling labor costs because government at all levels has imposed on business the responsibility of financing a growing lists of societal needs. The list of mandated labor costs is significant and growing: Social Security, Medicare, Minimum Wage, Unemployment Insurance, Workers Compensation, and Family and Medical Leave. And now, the President proposes additional mandated labor costs. Present governmental mandates have dramatically added to the cost of labor for most small businesses trying to compete with larger competitors, competitors who enjoy economy of scale advantages when purchasing everything from inventory, to health insurance.

As these government imposed costs on businesses have escalated, we have watched the general decline of numerous independent retail sectors, including independent grocers, independent druggists, hardware stores, mens wear retailers, etc. While Congress has exhibited considerable concern during the last 40 years with preserving the family farm, there has been little interest demonstrated by Congress in preserving independent, family-owned retail or service establishments.

Take for example, Mr. Chairman, a small independent tire retailer in a rural area of the midwest. What is the store owner to do when new labor costs, equaling at least 3.5% of payroll, are imposed by the federal government under the proposed Health Security Act? Remember these are labor costs that the store owner must pay regardless of the financial health of the business. To compensate for these added costs, the business owner may consider raising his or her prices in order to remain profitable. That option however, may not be viable in light of the fact that a Walmart store has recently opened in town. Another choice would be to reduce employee wages. However, that is not a viable option because some workers are already being paid the minimum wage. The third and most likely option for the employer is to reduce labor costs by reducing the size of the business's workforce.

And who will be the typical employees being laid off? They will be men and women presently employed in the retail and service industries. Indeed, virtually all studies have shown that these are the sectors of the economy which will face the greatest added cost under a system of employer mandates. They will be those with the least education, the least training. They will be those least able to find alternative employment. Conservative estimates have placed increased employment resulting from mandated benefits as high as a million and one half workers. In calculating the true costs of the President's program, Congress should not fail to calculate the added unemployment, food stamp and other welfare costs associated with putting

hundreds of thousands of additional workers in the unemployment lines as a result of employer mandates.

Over the last twenty years small business has been responsible for the majority of jobs created in this country. Job creation by large employers and the manufacturing sector have sharply declined. Our current economic recovery over the past two years has proven to be fragile at best. Continuing to impose added financial burdens on small business can only result in an adverse impact on potential economic growth.

Now some will argue that the potential economic impact of the employer mandates under the Health Security Act will be less severe than we anticipate. Why? Because a significant percentage of small employers will be eligible for the proposed federal subsidy intended for employers with fewer than 75 employees and an average wage of \$24,000 or less. However, small business owners fully understand that what the government gives, the government can take away. Recently the Congressional Budget Office released figures demonstrating that President Clinton's Health Security Act would cost the federal government an additional \$74 billion over 5 years rather than saving \$59 billion as the White House earlier had claimed. No sooner were these figures released than Senator Kennedy, who will have a major voice in crafting health care reform, announced that the program's costs could be reduced by eliminating or scaling back the proposed small business subsidy.

Most small business owners readily recognize that, if the employer mandates proposed under the Health Security Act go into effect, they will lose control over another significant percentage of their labor costs. They realize that the proposed small business subsidies are subject to the whim of Congress. Many tire dealers, when planning for retirement, relied on the belief that Social Security benefits would never be taxed. Unfortunately, they have learned the hard way that it is unwise to rely on the stability of government programs. Few tire dealers would be so foolish as to bet the future of their businesses on the permanence of any proposed small business subsidy under the Health Security Act. Nor would most small business owners be willing to rely on the stability of the proposed payroll caps or premium caps contained in the President's package. Older tire dealers can recall the initial payroll caps contained in the original Social Security Act. Middle aged tire dealers and rereaders are all too familiar with the disparity between the wage base subject to taxation under the original Medicare statute and today's Medicare wage base.

Experience has taught business owners that the costs imposed on business by most government programs only go up and usually exponentially! We can recall the Congressional debates in the mid 1960's when proponents of the proposed Medicare system estimated that, if adopted, Medicare would cost around \$10 billion in 1990. In reality, the figure was closer to **\$200 billion**.

Imagine, Mr. Chairman, that you drove into an independent tire dealership and asked what the cost would be for a front-end alignment and a brake job. The owner responded that the bill would be approximately \$150. Imagine that, when you returned to pick up your car, you were presented with a bill for \$3,000. We seriously doubt that you would ever again return to that tire dealership when your car needed service. You might even report the dealer to your state consumer agency for fraud. Perhaps our rather simplistic example will help members of the committee understand why most NTDR members, and, no doubt, most small business owners, are skeptical when the federal government offers its expertise in developing a comprehensive national health care reform program.

Does Congress have a role to play in improving the nation's health care delivery and health insurance systems? Of course it does. However, we believe that the greatest measure of improvement is likely to result from greater reliance on

strengthening competition and market mechanisms rather than through price controls, employer mandates, and a vastly expanded bureaucracy. We believe Congress could make an important contribution by developing truly equitable means of raising the resources necessary to finance health care or health insurance for the truly needy. And by equitable means we do not mean payroll taxes. Congress, working with the insurance industry and employers, should be able to develop programs to encourage voluntary small business purchasing entities that could help reduce the cost disparity between what large employers and small employers pay for insurance. Congress could demonstrate it is serious about helping to control rising health care costs by demonstrating the political will to tackle the malpractice reform issue. And certainly Congress could take steps to assure both the portability of health insurance coverage when workers change jobs, and a reduction in the incredible administrative costs associated with processing insurance claims.

NTDRA is eager to work with members of Congress to improve our current health care and health insurance delivery systems. We cannot, however, support initiatives that threaten the economic future of small-business owners, the jobs of small-business employees and, perhaps, the nation's economy in general as employer mandates would surely do.

We recognize the difficult task facing the Committee in crafting a health care reform bill. If we can provide any information that might be helpful to the Committee, we hope you will call on us. Again our thanks to the Committee and to you Mr. Chairman for allowing NTDRA to make its views known.

**STATEMENT OF THE
UNITED FOOD AND COMMERCIAL WORKERS INTERNATIONAL UNION
SUBMITTED TO THE
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
ON THE EMPLOYER MANDATE AND RELATED PROVISIONS IN
THE HEALTH SECURITY ACT**

FEBRUARY 3, 1994

The United Food and Commercial Workers International Union is the nation's largest private-sector union with 1.4 million members working in retail food, meat packing, food processing, shoe manufacturing, nursing homes and other industries. All collective bargaining agreements negotiated by the UFCW provide for health insurance benefits. Two thirds of our members receive their health benefits from jointly-trusted labor-management Taft-Hartley Funds. These Funds deliver service-oriented high quality health benefits. The UFCW's involvement in these Taft-Hartley Funds and over 40 years of collective bargaining experience has allowed the UFCW to develop an expertise in health care matters.

The UFCW believes that working Americans face an immediate and serious health care crisis. Twenty million working Americans have no health insurance. Eighty-five percent of the 38.5 million uninsured Americans are in families with working members. Some 2.2 million workers lost their health insurance last year because their employers stopped paying for their health care coverage. Forty percent of American families had their health benefits cut back by their employers because of increased costs.

Only if every American is guaranteed affordable health care coverage can we stop this upward spiral in the number of Americans who work hard every day, pay taxes, and yet are denied basic health insurance.

Universal Coverage

The centerpiece of President Clinton's Health Security Act (HSA) is universal coverage through an employer mandate. Reforming health care by mandating universal coverage accomplishes three important public policy goals: it eliminates the uninsured problem; it provides for a system of equitable financing; and it acts to contain cost shifting and medical inflation. Currently, the uninsured receive health care in the most inefficient way. The uninsured are the most costly to treat because they postpone preventive and primary care and wait until their condition lands them in the emergency room, where they receive the most costly health care available. The cost of this uncompensated care is then passed on by medical providers to the insured segment of the private sector in the form of a "cost shifting" tax. The President recognized this national problem in his State of the Union address when he said, "If you send me legislation that does not guarantee every American private health insurance...you will force me to veto the legislation." The UFCW believes that the only way to stop this unfair cost shifting is to require all employers to provide health insurance to every worker.

Employer Mandate

Clearly, a system that requires all employers to contribute to the cost of health insurance for their workers would reach the vast majority of the uninsured and bring an end to the cost shifting from employers who don't provide health protection to their employees, to those that do. Under our current health care system, responsible employers who provide health insurance to their employees are being penalized because they are paying additional premium cost to cover the uninsured and the uninsured working spouses of their employees. This cost shifting tax results in an unfair competitive disadvantage in many industries where insured employers "subsidize" employers who provide no insurance or substandard insurance to their employees.

Our current system of employer-provided health insurance is unraveling. Without an employer mandate, companies will continue to limit the scope of their coverage or eliminate it entirely in response to competitive pressure. An employer mandate would level the playing field and encourage firms to become more competitive by improving productivity and investment in their workers rather than through benefit cutbacks. The pressure on firms to drop insurance will only increase in the future as more and more firms seek a competitive advantage by eliminating these critical benefits.

The retail industries which are a major jurisdiction of the UFCW, have an acute health insurance problem. According to the Department of Commerce, only 32.9 percent of workers employed in the retail trades have health insurance coverage provided by their employers, 22.8 percent of retail employees have no coverage whatsoever and the remaining 45 percent have coverage through their spouses' employer or are working dependents covered by their parents. In contrast, 74.6 percent of workers in the manufacturing sector have health insurance provided by their employers.

Some of the most irresponsible employers in retail are the giants of the industry -- Wal-Mart and Kmart. Wal-Mart and Kmart have employment policies that undermine employer-based benefits. Wal-Mart, the nation's second largest private employer, provides health care coverage to only 43 percent of its 490,000 employees. Kmart, with a work force of 350,000, covers only 32 percent of its workers. Based on an analysis of IRS Form 5500's and actual plan documents, the UFCW estimates that Wal-Mart and Kmart together shifted over \$1 billion in health costs to other employers in 1993 alone. Because of these inequities and unfair subsidies to corporate giants such as Wal-Mart and Kmart, the current employer-based health care system is on the brink of collapsing.

Part-time Workers

The Health Security Act will also resolve the uninsured status of one of the fastest growing groups of workers -- part-timers. According to the Department of labor, only 28% of all part-time employees working in large and medium-size firms had health insurance coverage in 1991. Many employers in the retail and service industries have deliberately excluded part-time workers from health insurance eligibility for both cost and competitive reasons. At Wal-Mart, employees must work an average of 28 hours per week in order to retain continued eligibility for health insurance benefits. However, fewer than 50% of the Wal-Mart workforce meets this standard. At the same time, the health security of Wal-Mart's insured employees can be manipulated by management's control over scheduling of hours.

The Clinton health reform plan addresses the special problems of part-time workers by requiring employers to contribute a premium on a pro-rated basis for all part-timers working between 40 and 120 hours per month. If an employee works more than one part-time job, each employer has an obligation to contribute a pro-rated portion of a full-time insurance premium. This system fairly distributes costs among employers, and eliminates cost shifting. In addition, part-timers become eligible for the same benefits as full-time employees, eliminating the creation of multiple benefit levels.

One area of the Health Security Act that concerns the UFCW is the fact that employers who schedule employees to work under 40 hours per month are exempt from health insurance premium responsibility for those part-time employees. The UFCW believes that companies like Wal-Mart and Kmart will use this loophole to undermine universal coverage. What seems like an inefficient scheduling and hiring practice could become economic if a particular group of workers are excluded from mandated coverage. Therefore, we hope Congress will prevail in closing this coverage gap in order to create a complete system of universal coverage.

Equitable Financing through Employer Mandates

The Health Security Act requires employers and workers to share the costs of health insurance, with employers contributing 80% of the total premium cost and employees

paying a maximum of 20%. The Clinton plan also allows employers to contribute up to 100% of the total premium cost if they wish to, or based on negotiations with a labor union.

Opponents of the mandate have suggested a compromise by lowering the employer premium responsibility to 50%. The UFCW believes that a 50% employer mandate is an unfair tax burden on working Americans that would create a multi-billion dollar windfall for companies, and at the same time undermine the principle of universal coverage.

Currently, at least two-thirds of the UFCW's members pay no premium for their health insurance coverage. Those UFCW members who pay premium based on collective bargaining, typically pay substantially less than 20% of the total premium cost. In contrast, employees at Wal-Mart on average pay 36% of the total premium cost, and employees at Kmart on average pay 33% of the total premium cost. Millions of American workers without union protection are being forced to assume an unacceptable financial burden in order to maintain health insurance coverage for their families.

National Core Package of Benefits

The Health Security Act further reinforces the principle of universal coverage through employer mandates by requiring a standard package of comprehensive benefits be made available to all Americans. The Clinton plan also requires a choice of health plan types -- fee for service, HMO, and a combination plan option. Each plan has defined deductibles, co-insurance, and out of pocket maximums. The Clinton core benefit package is quite similar to health plans negotiated by the UFCW

These model plans offer a necessary base of health benefits that will provide real security and enhance the health status of all Americans. Any attempt by the opponents of health reform to diminish the Clinton core benefit package should be blocked by Congress. Weaker benefits will only undercut the principle of universal coverage, threaten public health, and turn the health security promise into a public fraud.

Companies, like Wal-Mart, oppose the national core benefit package proposed in the Health Security Act because they are currently providing substandard health plans to their eligible employees that shift significant risk and cost to workers and their family. The best Wal-Mart health plan (\$250 single/\$750 family deductible; \$1,250 single/\$2,500 family out of pocket maximum) is still of lesser value than the Clinton indemnity core plan (\$200/\$400 deductible; \$1,500/\$3,000 out of pocket maximum). In addition, the Wal-Mart health plan requires employees to pay 40 percent co-insurance for out-of-network services compared to 20 percent under the Clinton plan. The Health Security Act standard benefit package also provides superior coverage for preventive medical services, skilled nursing facility, vision and hearing, dental, and mental/substance abuse compared to both the Wal-Mart and Kmart plans. (see attached comparison)

Employer practices that shift significant health insurance cost responsibility onto low-wage workers threatens the standard of living of tens of millions of Americans. This is best exemplified by the following analysis of the impact of Wal-Mart's plans on its eligible employees. A Wal-Mart employee who elects the lowest deductible family coverage in 1993 would pay \$58 per pay period in premium contributions, or \$1,508 per year. This premium cost would represent 7.5 percent of the income of a \$20,000 per year employee, and 10 percent of the income of a \$15,000 per year employee. In contrast, the Health Security Act caps a worker's premium responsibility to 3.9 percent of family income (under \$40,000).

Moreover, at least two of the plans offered by Wal-Mart do not provide adequate protection for employees earning under \$25,000 annually. Specifically, the \$750 deductible plan (\$750/\$2,250 deductible; \$3,750/\$7,500 out of pocket maximum) and

the \$1,000 deductible plan (\$1,000/\$3,000 deductible; \$5,000/\$10,000 out of pocket maximum) could bankrupt a low-wage worker if the maximums were reached in a particular year.

Health Reform and Employer Mandates - Historic Opportunity

In the past two decades working middle-class Americans have experienced a decline in real income and diminishing expectations about their economic future and that of their children. Our failure as a society to secure access by all Americans to adequate health insurance weakens our sense of community and threatens the American standard of living -- the foundation of our political system.

Congress gains an opportunity to alter historical patterns maybe once a generation. This is that time. The historic opportunity is here and now -- 1994 is the year of real national health care reform. The same forces who unsuccessfully opposed the Norris-LaGuardia Act in 1932, Social Security in 1935, Fair Labor Standards Act in 1938, and Medicare in 1965, are promoting the same false, anti-social, and fear-mongering arguments that were used 60 years ago in the current health care debate. They raise the specter of massive unemployment, social upheaval, and "socialized" government controlled medicine in their opposition to the Health Security Act and its goal of universal coverage through employer mandates. Yet where is the historical evidence for these "doomsday" outcomes. They don't exist, nor is there academic research support for their negative arguments.

The UFCW and its predecessor unions have supported national health reform since it was first proposed by President Harry Truman. Our 1.4 million members have waited along time for this moment. We are depending on Congress to do the right thing for the people of this great nation and pass a National Health Care Act that provides universal coverage to every American and that affords equitable financing through an employer mandate. The UFCW will exert every resource at its command to attain this goal and support Congress' efforts to reach this critical public policy objective.



Wal-Mart's and Kmart's Limits in Health Coverage Compared to Clinton's Standard Benefit Package (Fee for Service)

Clinton Plan	Wal-Mart	Kmart
1. Preventive Coverages No copays	No coverage	No coverage
2. Skilled Nursing Facility 20% copay at 100 days	50%/60 days	No coverage
3. Out patient Pres. Drug Deductible/20%, \$1,000 Stop Loss	Same but no Stop Loss	Same but no Stop Loss
4. Vision & Hearing Care Deductible/20%	No coverage	No coverage
5. Dental and Orthodontics Children under 18 over 18 in 2001 Deductible/20%	No coverage	No coverage
6. Mental & Nervous & Substance Abuse In-Patient Deductible/20% Out-Patient Deductible/20% after 2001 No limits after 1998	In-Patient 50%, \$1,000/year Out-Patient 50%, 30 days Lifetime maximum-\$20,000	In-Patient 20% to 35 days Out-Patient 50% to \$2,500 Lifetime maximum-\$25,000
7. Pre-existing Condition Immediate coverage	6 months of no treatment 12 month waiting period	12 months of no treatment 12 month waiting period
8. Eligibility Initial - All Covered Ongoing - All Covered	90 day waiting period 28 hours/week	3 month waiting period 30 hours/week
Organ transplants to be decided	covered	covered to \$10,000
Podiatry to be decided	covered	no coverage
Chiropractic to be decided	no coverage	deductible/20%

Based on the above limitations and the higher Out-of-Pocket costs to Wal-Mart and Kmart employees and not considering employee premiums, the Clinton Plan would be 120% (conservative) richer than the two store plans after 2001 increases.



